EVIDENCE FOR ADDITION ITEM # 18 IS ON:

FILM No. G 119 MAR -7 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

162 0584

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Washington, D.C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place): 6 mons. 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural give location): 2009 Wyoming Avenue N.W.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Paul	Humiston	ALLING	January	18	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male Male	W-US	married	7-16-96	52 yrs.	6	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreign Service	US Government	Conn.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ALLING, Edson	HARRISON, Lula

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes WWI		wife: Mrs. Romaine Alling

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Bronchopneumonia	2 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Carcinomotosis	Nov. 48
(c)	Carcinoma of lung; Probably lung primary	Nov. 48

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
December 48	Carcinoma of right pleural cavity	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 9, 1948, to Jan. 18, 1949, that I last saw the deceased alive on Jan 18, 1949, and that death occurred at 6:10 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. HARRISON, Jr.,	Lt. MC USN	US Naval Hospital, Bethesda, Md.	1-18-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-21-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-18-49	Mary C. Patterson	Joseph Gawler & Sons,	1756 Penn. Ave., N.W. Washington, D.C.

VS. A15

RECEIVED
JAN 20 1949
BUREAU V. S.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

976 164C 0585

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Monty MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 407 White Stone Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
STREET ADDRESS (If rural give location) 407 White Stone Rd

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Blanchard Clewley (Last) Baker

4. DATE OF DEATH (Month) 1 (Day) 12 (Year) 1949

5. SEX Fe
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced
8. DATE OF BIRTH Sept 4 1908
9. AGE last birthday 40 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone
10b. KIND OF BUSINESS OR INDUSTRY Operator
11. BIRTHPLACE (State or foreign country) Madison Wis
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Nichols D. Baker
14. MOTHER'S MAIDEN NAME Mary B. Clewley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Adelia B Kloak

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemorrhage due to bullet

Antecedent cause(s) wound thru skull (suicide)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) suicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Silver Spring (COUNTY) Monty. (STATE) md
TIME OF INJURY (Month) Jan (Day) 11 (Year) 1949 (Hour) 2:15 P.M.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? 32 cal colt automatic

22. I hereby certify that I attended the deceased from Dep Med Exam Case, that I last saw the deceased alive on ....., 19....., and that death occurred at 2:15 P.m., from the causes and on the date stated above.

SIGNATURE Frank J. Broschart (Degree or title) M.D. Dep Med. Exam
ADDRESS Gaithersburg Maryland
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE Jan. 15, 1949
NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
LOCATION (City, town, or county) Washington D.C. (State)

DATE REC'D BY LOCAL REG. Jan. 12, 1949
REGISTRAR'S SIGNATURE Josephine M. Schaeffer
24. FUNERAL DIRECTOR Jas. Fowlers Sons
ADDRESS Wash. D.C. 1756 Pa. Ave N.W.

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1
94a

0586

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Montgomery

City or town Westmoreland Hills
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Worthington Dr
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George M Barnard

3. (b) Social Security Number

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Marion D Barnard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6 1881

8. AGE: 67 Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace New Castle Ind
(Town, county, and state)

10. Usual occupation Lawyer

11. Industry or business Inter State Commerce Comm

FATHER
12. Name William O Barnard
13. Birthplace Ind

MOTHER
14. Maiden name Mary V Ballinger
15. Birthplace Ind

16. Informant Marion D Barnard

Address H 2 Worthington Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1948 (month) (day) (year)

Cemetery or crematory Longwood Cem

Location Kennett Square, Pa.

18. Funeral director S H Hines Co

Address 2901-14 St. N.W.

19. 1-3 1949 (Date rec'd by registrar) W. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 2 1949 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1948, to January 2 1949 and that I last saw him alive on January 2 1949

Immediate cause of death Coronary Thrombosis — DURATION 2 hrs

Due to coronary sclerosis — 1+ yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE R. B. Norris M.D. M. D. or other

Address 2204-R St NW. Date signed 1/2/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1943
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

260 61 0587

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 914 Fifth St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI SAW

3.(a) FULL NAME: BARNES, James Samuel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10 September 1874

8. AGE: Years	Months	Days	If less than one day
74	3	27	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: BARNES, Charles Henry dec.
13. Birthplace: Md.

MOTHER
14. Maiden name: THOMAS, Margaret Ann dec.
15. Birthplace: Md.

16. Informant: daughter: Mrs. Catherine Young
Address: 914 Fifth St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-10-49 (month) (day) (year)

Cemetery or crematory: St. Joseph's Cemetery

Location: Morganza, Md.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U St., N. W., Wash., D.C.

19. 1-7 1949 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 January 1949 at 12:34A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 December 1948 to 7 January 1949 and that I last saw him alive on 7 January 1949

Immediate cause of death: Hemorrhage, Cerebral	DURATION
Due to: Arteriosclerosis, Generalized	
Due to: Diabetes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. Young (J. H. YOUNG, Lt., JG MC USN) M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-7-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

770.0
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0588

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Birth

Hospital, institution, or street address where death occurred: Suburban Hospital, Old Geo. Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges.

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 E - Crescent Rd.,
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Infant (Male) Baxter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	—

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-'49

8. AGE: Years | Months | Days | If less than one day hrs. 2 min.

9. Birthplace Suburban Hospital Bethesda, Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Rollison Hall Baxter
13. Birthplace Chestertown Maryland

MOTHER
14. Maiden name Catherine Rebecca Cochran
15. Birthplace Glena Maryland

16. Informant Rollison Hall Baxter
Address Greebelt, Maryland.

17. Burial Date thereof Jan 8, 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory George Washington Memorial Cemetery

Location Riggs Rd. Hyattsville, Md.

18. Funeral director J. Arthur Walters

Address 254 Carroll St NW, Wash. 12. D.C.

19. 1/8/ 1947 W E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1949 at 7:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-7- 1949, to 1-7- 1949 and that I last saw him alive on 1-7- 1949

Immediate cause of death Erythroblastosis Foetalis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D.
M. D. or other

Address Silver Spring, Md Date signed 1-7-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

517

RECEIVED
JAN 11 1949
BUREAU V. S.

0589

526
106 lb

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Tenn. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (In this place) 1 mons. 6 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Memphis
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location) 3704 Friartuck Road ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Thurman	Berry	BAXTER	January	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	single	9-16-04	44 yrs.	4	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknown	unknown	Kentucky	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BAXTER, Wm. Avery	BERRY, Una Mae

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes Peace Time		sister: Mrs. Mary Hines

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchopneumonia (Post Operative) bilateral — days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Right Lower Lobectomy

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-7-49	Lobectomy - Bronchiectasis, rt.lower lobe	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec. 13, 1948, to Jan. 19, 1949, that I last saw the deceased alive on Jan 19, 1949, and that death occurred at 8:18 P. m., from the causes and on the date stated above.

SIGNATURE R. N. Shelley (Degree or title) ADDRESS DATE SIGNED

R. N. SHELLEY, Cdr. MC USN, US Naval Hospital, Bethesda, Md. 1-19-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal Burial	Jan. 21, 1949	Bardwell Cemetery	Bardwell, Kentucky

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
1-20-49	Mary E. Patterson Mary E. Patterson	W.W. CHAMBERS, CO. 1400 Chapin St. Wash, D.C.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0590

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

421.4

CERTIFICATE OF DEATH

92.2

Reg. Dist. No. 214

1. PLACE OF DEATH· COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ednor — LENGTH OF STAY (in this place) life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ednor
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Edward (Last) Bond

4. DATE OF DEATH (Month) Jan (Day) 26 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Widowed	10-12 1864	84 yrs.	3	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist Engineer		Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm Stabler Bond	Mary Taylor Steer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no			Francis A. Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Cardiac dilatation — 3 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Valvular heart disease — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dep. Med. 19 Exam case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 3:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank J. Broschart M.D. Dep. Med. Exam. — ADDRESS Gaithersburg — DATE SIGNED Maryland

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	Jan. 28, 1949	Cedar Hill Crematory	Suitland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 27, 1949	Josephine M. Schaeffe	Warner E. Pumphrey	Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0591

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

174
480

CERTIFICATE OF DEATH

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Oakdale Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakdale | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakdale Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANNIE	Naomi	BREADY	Jan.	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
Female	White	SINGLE	Feb 6, 1889	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Redland, Montgomery Co. Md.	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Calvin BREADY	Eliza Lovena BREADY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Calvin Bready (father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intestinal Obstruction — 5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of Uterus with — 18 mos.

(c) Metastases

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Colostomy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 9, 1948	Carcinoma of Uterus with Metastases	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10/11, 1948, to 1/23, 1949, that I last saw the deceased alive on 1/10, 1949, and that death occurred at 10 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
F. W. Bird	M.D	Sandy Spring Md	1/23/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/25/1949	Rockville Union	Rockville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 24-49	Gertrude B Sawler	Robert R. Humphrey	Bethesda, Md.

VS. A15

RECEIVED
FEB 3 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

442 0592
131a

CERTIFICATE OF DEATH

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Damascus | LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Purdum, RFD Monrovia
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Everett	W.	Breece	Jan.	31	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Feb. 14, 1883	65 yrs.	11	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Accountant		Metuchen, N. J.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Franklin Breece	Gussie Lane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	579-05-5315	Mrs. Carrie Breece - Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	15 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension - marked	10 yrs.
	(c) Cardio vascular renal disease	15 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. 31, 1949, to Jan 31, 1949, that I last saw the deceased alive on Jan. 31, 1949, and that death occurred at 12 Noon m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. McKendree Boyer M.D. Druid Theatre Bldg. Damascus, Md. 1/31/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 3, 1949	Fort Lincoln	Bladensburg, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 31, 1949	Della K. Burdette	S.H. Hines Co. 2901 - 14th St. N.W. Washington, D.C.

VS. A15

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FEB 4 1949
BUREAU V. S.

0593

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.0

CERTIFICATE OF DEATH

93d Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Paul RD.	STREET ADDRESS (If rural, give location) St. Paul Rd.

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) (Last) Breyere

4. DATE OF DEATH (Month) (Day) (Year) January 7, 1949

5. SEX Female

6. COLOR OR RACE Wh.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH July 26, 1871

9. AGE last birthday 77 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Brockville, Canada

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown La Melle

14. MOTHER'S MAIDEN NAME Philomena LaMelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Edward J. Breyere - son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — 5 min.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Arteriosclerotic Heart Dis — 2 mo. to my own knowledge

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-2, 1948, to 1-7, 1949, that I last saw the deceased alive on 1-2, 1949, and that death occurred at 5:15 A m., from the causes and on the date stated above.

SIGNATURE John S. Rogers (Degree or title) M.D. — ADDRESS 9601 Sutton Pl., Silver Spring, Md. — DATE SIGNED 1-7-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Jan. 10, 1949 — NAME OF CEMETERY OR CREMATORY St. Mary's Catholic — LOCATION (City, town, or county) (State) Rockville, Md.

DATE REC'D BY LOCAL REG. Jan. 9, 1949 — REGISTRAR'S SIGNATURE Josephine M. Schaeffer

24. FUNERAL DIRECTOR Warner C. Pumphrey, Inc. — ADDRESS Silver Spring, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

570.5
122.5

0594

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Montgomery — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pennsylvania — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Uniontown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital	STREET ADDRESS (If rural, give location): 59 Evergreen Terrace

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Nathan	(n)	Broad	1	22	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	W-U.S.		9-30-05	43 yrs.	3	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Capital Transit Co.	New York State	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BROAD, Isrel	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWII		sister: Mrs Sam B. Koidnov

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Toxemia	? died few min. after arrival at hosp.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute purulent Peritonitis due to	
	(c) intestinal obstruction	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dep Med Exam Cash, 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 2:50 P m., from the causes and on the date stated above.

SIGNATURE Frank J. Bronhart M.D. (Degree or title) ADDRESS Gaithersburg Md DATE SIGNED 1-23-49

Dep. Med. Exam.

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal ~~burial~~		Hopwood Cemetery	Hopwood, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-23-49	Mary C. Patterson	Pumphrey Funeral Home,	7557 Wisconsin Ave. Bethesda, Md.

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JAN 25 1949
BUREAU V. S.

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445 Nunes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

102 Reg. Dist. No. 215

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 3 mons. 13 da.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location) 1909 L St., N.W. ✓

3. NAME OF DECEASED (Type or Print) (~~First~~) (Middle) (~~Last~~) BROOKS, Robert James			4. DATE OF DEATH (Month) (Day) (Year) January 12 1949		
5. SEX male	6. COLOR OR RACE negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 9-12-07	9. AGE last birthday 41 yrs.	If under 1 year Months 3 Days 13 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME BROOKS, Aldridge			14. MOTHER'S MAIDEN NAME HANEY, Ella		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If year, give war or dates of service) WWII		16. SOCIAL SECURITY NO.	17. INFORMANT brother: Mr. Charles A. Brooks		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	1 month
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension "malignant"	4½ mons.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 29, 1948, to Jan. 12, 1949, that I last saw the deceased alive on Jan 12, 1949, and that death occurred at 6:35 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S. R. Mills Jr.	S. R. MILLS, Jr., Lt. JG MC USN	U.S. Naval Hospital, Bethesda, Md.	1-12-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-17-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-12-49	Mary C. Patterson	Henry S. Washington & Son,	4925 Deane Ave. N.E. Wash., D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

260/61

0596

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Tokoma Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanatarium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D C County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 2001 - 2nd St N E. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ELSIE BROWN

3.(b) Social Security Number

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Max H Brown

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March - 2 - 1900

8. AGE: Years 48 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER: 12. Name: GABRIEL SHERR

13. Birthplace: RUSSIA

MOTHER: 14. Maiden name: RACHEL STOCKMAN

15. Birthplace: RUSSIA

16. Informant: Max H Brown

Address: 2001 - 2nd St N E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 25-49 (month) (day) (year)

Cemetery or crematory: Adas Israel Cem.

Location: Washington D C

18. Funeral director: Bernard Dangansky & Son

Address: 3501 - 1 Ave St N W

19. Jan - 23 1949 (Date rec'd by registrar) J Hilton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23, 1949, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31, 1946, to January 23, 1949 and that I last saw her alive on January 22, 1949

Immediate cause of death: Uremia, chronic nephritis — DURATION: 1 yr

Due to: arteriosclerosis — 3 yrs

Due to: Diabetes — 3 yrs

Other conditions: Hypertensive cardiac disease coronary thrombosis, cereberal hemorrhage blindness due to hemorrhage. (Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 1/23/49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

EVIDENCE FOR ADDITIONAL INFO. # 18 15 OR

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0597

FILM No. G 119 MAR 28 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (In this place) 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7912 Piney Branch Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Illinois COUNTY Bureau
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sheffield
STREET ADDRESS (If rural, give location) Rt #2

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Eugene (Last) Burns

4. DATE OF DEATH (Month) Jan. (Day) 19 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH 1 Nov 1866

9. AGE last birthday 82 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tiskilwa Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Michael Burns

14. MOTHER'S MAIDEN NAME Ellen McCarthy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Mrs W.C. Dexter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of right lung, probably primary (3/28/49 alive)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

INTERVAL BETWEEN ONSET AND DEATH: ? / 5 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1948, to 19 Jan, 1949, that I last saw the deceased alive on 19 Jan, 1949, and that death occurred at 2:05 P m., from the causes and on the date stated above.

SIGNATURE William D. Aud, (Degree or title) M.D. ADDRESS 9806 Colesville Rd Silver Spring, Md DATE SIGNED 19 Jan 49

23. BURIAL, CREMATION REMOVAL (Specify) Shipment

DATE Jan 20, 1949

NAME OF CEMETERY OR CREMATORY Mt. Olivet

LOCATION (City, town or county) Kewanee, Illinois (State)

DATE REC'D BY LOCAL REG. Jan 19, 1949

REGISTRAR'S SIGNATURE Josephine M. Schaeffer

24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

443 92a 0598

Reg. Dist. No. 714

1. PLACE OF DEATH
COUNTY MONTGOMERY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRINGS. | LENGTH OF STAY (In this place) 11 MONTHS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS JOLLIFE NURSING HOME RFD #2 SILVER SPRINGS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE WASH. D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WASH. D.C.
STREET ADDRESS (If rural, give location) 2526 PENNA AVE S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) RAFFAELA (Middle) (NONE) (Last) CARRELLO
4. DATE OF DEATH (Month) JANUARY (Day) 11 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE.	WIDOWED	OCT 23, 1879	69 yrs.	2	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): NAPLES ITALY
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ANTONIO MILANO
14. MOTHER'S MAIDEN NAME: ANGELINA A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE.
17. INFORMANT: DAUGHTER Mary C Barzilla

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CARDIAC DECOMPENSATION	1 YEAR
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) AORTIC STENOSIS (CALCIFIC)	YEARS
	(c) HYPERTENSIVE HEART DISEASE.	YEARS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. GENERALIZED ARTERIOSCLEROSIS YEARS

19a. DATE OF OPERATION: NONE
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from FEBRUARY 48 to JAN 11, 1949, that I last saw the deceased alive on JANUARY 10 1949, and that death occurred at 7:57 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Vincent J. DiFrancesco M.D. 2436 L'Enfant Square SE. Jan 11, 1949.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan. 14 1949
NAME OF CEMETERY OR CREMATORY St Marys Cemetery
LOCATION (City, town, or county) (State) Wash D.C.

DATE REC'D BY LOCAL REG. Jan. 11, 1949
REGISTRAR'S SIGNATURE Josephine M. Schaeffer
24. FUNERAL DIRECTOR ADDRESS
James T. Ryan Inc 317 Penna SE Wash, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0599

420.1

CERTIFICATE OF DEATH

131a

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unity
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Unity, Gaithersburg, R.F.D. 2
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Dr. (Middle) Milton Hughes (Last) Christie

4. DATE OF DEATH: (Month) Jan. (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Mar. 7, 1858

9. AGE last birthday: 90 yrs. If under 1 year: Months 10, Days 2, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Physician

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West. Sunbury, Pa.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Hughes Christie

14. MOTHER'S MAIDEN NAME: Nancy McClain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dr. A. C. Christie

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Thrombosis	1 week
Antecedent cause(s)	Generalized Arteriosclerosis	? years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular-renal Disease	
	Coronary Thrombosis March 1948&January 1949	
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: None (CITY OR TOWN) ----- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): None m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: None

22. I hereby certify that I attended the deceased from March, 1948, to January 1949, that I last saw the deceased alive on Jan. 9, 1949, and that death occurred at 12:15a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. McKendree Boyer M.D. ADDRESS: M. D. Damascus, Maryland DATE SIGNED: January 10, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: Jan. 12, 49 NAME OF CEMETERY OR CREMATORY: Pine Grove LOCATION (City, town, or county) (State): Corry, Erie Co., Pa.

DATE REC'D BY LOCAL REG. Jan 10 1949 REGISTRAR'S SIGNATURE: Della N. Burdette

24. FUNERAL DIRECTOR: Warren E. Pumphrey, Inc. ADDRESS: Silver Spring, Md.

RECEIVED
JAN 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

756.2

0600

CERTIFICATE OF DEATH

157 g

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4046 Grant St., N.E., Apt. 102
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

CLAYTON, George Hugh III

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 7, 1948

8. AGE: Years | Months | Days: 28 | If less than one day ..... hrs. ..... min.

9. Birthplace: Bethesda, Md. (rural)
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: CLAYTON, George Hugh, JR
13. Birthplace: Fla.

MOTHER
14. Maiden name: OLEJARSKI, Alexandra
15. Birthplace: N.Y.

16. Informant: father: George H. Clayton, FCl USN
Address: 4046 Grant St., N.E., Apt.102, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-7-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers FC

Address: 1400 Chapin St, N.W., Wash., D.C.

19. 1-6- 1949 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 January 1949, at 3:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 December 1948, to 5 January 1949 and that I last saw him alive on 5 January 1949

Immediate cause of death: Congenital duodenal valve formation

Due to: causing intestinal obstruction

Due to: Emaciation

Bronchopneumonia

Other conditions: atelectasis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Margileth
A. M. MARGILETH, Lt JGMC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-6-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

321
830

0601

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8509 Hempstead Ave.
(If rural, give LOCATION)
2.(a) Ever in veteran name war No

3.(a) FULL NAME EUNICE A. CLEMENTS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Sidney Clements
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 7, 1848

8. AGE: Years	Months	Days	If less than one day
100	3	0	..... hrs. ..... min.

9. Birthplace Boston, Mass.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

MOTHER FATHER
12. Name Unknown - Dempster
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown - Hurd
15. Birthplace Unknown

16. Informant Charles K. Berlin
Address 8509 Hempstead Ave. Bethesda, Md.

17. Burial Date thereof Jan. 10, 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Congressional Cemetery
Location Washington, D.C.

18 Funeral director Wm Reuben Pumphrey Funeral Home
Address Bethesda, Maryland

19. 1/9/49 19 ..... H. E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1949, at 12 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to January 7 1949 and that I last saw her alive on January 6 1949

Immediate cause of death	DURATION
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension, arteriosclerosis and age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Jaggers M.D.
M. D. or other
Address 5707 Wise Ave. Date signed 1/7/49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 11 1949
BUREAU V. S.

EVIDENCE FOR CORRECTION OF AGE SHOWN ON:

0602

FILM No. G 118 JAN 17 1949

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4221
93d

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 E. Primrose St.
(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American

3.(a) FULL NAME SAMUEL A. CLICKNER JR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Florence Clickner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 9, 1876

8. AGE:	Years	Months	Days	If less than one day
72	72	21	26	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Retired Clothing Salesman

11. Industry or business

FATHER
12. Name Samuel A. Clickner Sr.
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden name Jane E. Reed
15. Birthplace Baltimore, Md.

16. Informant Mr Kerman J. Rosenbaum

Address 110 Primrose St. Ch. Ch. Md.

17. Removal (Burial, cremation, or removal, Which?) Date thereof 1/6/49 (month) (day) (year)

Cemetery or crematory

Location Baltimore, Maryland

18. Funeral director Wm. J. Tickner & Sons

Address Baltimore, Maryland

19. 1/6 1949 (Date rec'd by registrar) N. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 - 1949 at 10 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1949 to Jan 5 1949 and that I last saw him alive on Jan 5 - 1949

Immediate cause of death	DURATION
Acute Congestive heart failure	1 day
Due to Chr. Cardio vascular	?
Due to disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE E. G. Bauersfeld, M.D. M. D. or other

Address Bethesda, Md. Date signed 1/

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU V. S.

Signed by permission of medical examiner - Dr Brosbart
1/6/49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420.0 0603

CERTIFICATE OF DEATH 93d Reg. Dist. No. 414

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

T

VS. A15

1. PLACE OF DEATH
COUNTY MONTGOMERY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING
LENGTH OF STAY (in this place) 20 Yrs. plus
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING
STREET ADDRESS (If rural, give location) 419 - Hamilton Ave.

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) HOWARD (Last) COALE

4. DATE OF DEATH (Month) JAN. (Day) 7, (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH AUG. 25, 1884

9. AGE last birthday 64 yrs. If under 1 year: Months 4, Days 13; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTOMOBILE DEALER

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) BALTIMORE COUNTY, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE B. COALE

14. MOTHER'S MAIDEN NAME ZIPPORAH A. BUSH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT MR. VAUGHAN COALE - SON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Instant.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic heart disease	4 years
	(c) with Cardiac decompensation	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1949, to Jan. 7, 1949, that I last saw the deceased alive on Jan. 7, 1949, and that death occurred at 4 P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Bruce V. Benjamin, M.D. ADDRESS Bethesda, 14, Md. DATE SIGNED 1/7/49

23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL | DATE JAN. 7/49 | NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | LOCATION (City, town, or county) (State) WASH D.C. Baltimore, Md

DATE REC'D BY LOCAL REG. Jan. 7, 1949 | REGISTRAR'S SIGNATURE Josephine M. Schaffer

24. FUNERAL DIRECTOR Martin W. Hysong Co - ADDRESS Washington, D.C.

RECEIVED
JAN 12 1949
BUREAU V. S.

0604

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

921.0

CERTIFICATE OF DEATH

195d Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery Co MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Md
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5032 - Bradley Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Md.
STREET ADDRESS (If rural, give location) 5032 - Bradley Blvd.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Theodore (Last) Coleman

4. DATE OF DEATH (Month) Jan (Day) 6 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Oct 17, 1948
9. AGE last birthday yrs. If under Months 2 I year Days 20 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas L. Coleman
14. MOTHER'S MAIDEN NAME Matilda Boose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Thomas L. Coleman (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxia due to Vomitus

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: Found dead in carriage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accidental
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Bethesda (COUNTY) Monty (STATE) md
TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 5 1949 8 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep. Med. Exam. Case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 5:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank J. Bronhart M.D. ADDRESS Dep. Med. Exam. Gaithersburg Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/8/49
NAME OF CEMETERY OR CREMATORY ~~Cedar Hill~~ Wash. Mch. Colm.
LOCATION (City, town, or county) (State) ~~Suitland Md.~~ Wash. D.C.

DATE REC'D BY LOCAL REG. 1-8-49
REGISTRAR'S SIGNATURE W.E. Jobes.
24. FUNERAL DIRECTOR ADDRESS Chevy Chase Funeral Home 5103 - Wis. ave. N.W. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 11 1949
BUREAU V. S.

0605

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

002 13b Reg. Dist. No. 215

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 12 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ✓
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location) 719 Euclid St., N.W.

3. NAME OF DECEASED (Type or Print)	(First) RALPH	(Middle) Wenfield	(Last) COLEMAN	4. DATE OF DEATH	(Month) January (Day) 30 (Year) 1949
5. SEX MALE	6. COLOR OR RACE NEGRO	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Jan 22, 1918	9. AGE last birthday 31 yrs.	If under 1 year Months 0 Days 5 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Student	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME COLEMAN, Robert		14. MOTHER'S MAIDEN NAME SCOTT, Elizabeth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWII	16. SOCIAL SECURITY No.	17. INFORMANT Mother: Mrs. Elizabeth Coleman			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pericarditis, Tuberculosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pneumonia, Tuberculosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep. med. 19 Exam Case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8:10 A.m., from the causes and on the date stated above.

SIGNATURE Frank J. Bronhart M.D. (Degree or title) Dep. Med. Exam. ADDRESS Gaithersburg Md. DATE SIGNED 1-30-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 2-3-49	NAME OF CEMETERY OR CREMATORY National Cemetery	LOCATION (City, town, or county) (State) Fredericksburg, Va.
DATE REC'D BY LOCAL REG. 1-31-49	REGISTRAR'S SIGNATURE Mary C. Patterson	24. FUNERAL DIRECTOR W. Ernest Jarvis, 1432 U St., N.W. Wash., D.C.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

331 83a

0606

Reg. Diat. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring, Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Jolliffe Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Virginia County

City or town Roanoke (If outside city or town limits, write RURAL and give nearest town)

Street No. 2431 Stanley Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

SAMUEL HENRY COLEMAN

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife Frances Rutherford Goodwin

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1872

8. AGE: Years	Months	Days	If less than one day
76	5	18	hrs. min.

9. Birthplace Brookeville, Md. (Town, county, and state)

10. Usual occupation Retired -- Wholesale Dry Goods

11. Industry or business

FATHER

12. Name S. H. Coleman

13. Birthplace Staunton, Va.

MOTHER

14. Maiden name Lavinia Magruder

15. Birthplace Montgomery County, Md.

16. Informant Mrs. LeBaron C. Stinnett, daughter

Address 5618 Wisconsin Ave., Chevy Chase, Md.

17. Shipment & burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1949 (month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location Roanoke, Roanoke Co., Va.

18. Funeral director Warner E. Pumphrey, Inc.

Address 8434 Ga. Ave., Silver Spring, Md.

19. Jan 17 1949 Josephine M. Schaefer Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1949, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27 1948 to 1-16 1949 and that I last saw h[illegible] alive on 1-16 1949

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Senile Debility	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. Pogue M.D. M. D. or other

Address 9601 Colesville Rd. Silver Spring, Md. Date signed 1-17-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

802.5

0607

CERTIFICATE OF DEATH

169

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Forest Glen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, Institution, or street address where death occurred:

B&O R.R. crossing

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1030 Fairmount St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Betty Conway

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1930

8. AGE: Years: 18 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Beautician

11. Industry or business:

FATHER — 12. Name: Ivory Edgar Conway

13. Birthplace: N.C.

MOTHER — 14. Maiden name: Pearl Giles

15. Birthplace: N.C.

16. Informant: Ivory E. Conway (Father)

Address: 1030 Fairmont St. N.W.

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Jan. 5, 1949 (Month) (Day) (Year)

Cemetery or crematory: Forest Lawn Memorial

Location: Suitland, Md.

18. Funeral director: Robert L. Snowden

Address: Rockville, Md.

19. Jan. 5 1949 Josephine M. Schaeffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4 1949 at 11:59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1949 to Dec. 4 1949

and that I last saw him alive on 19

Immediate cause of death	DURATION
Fracture of skull	Instantly
Due to: struck by train	
Due to:	
Other conditions: Multiple fractures	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 1-4-49

Where did injury occur? Forest Glen (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) B&O RR Crossing

Means of injury: Struck by train Injured at work? no

23. SIGNATURE: Frank J. Brockhurst M.D.

Diff. Med. Exam. M. D. or other

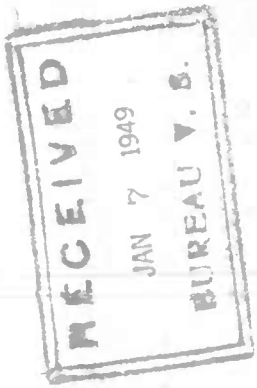
Address: Gaithersburg Md Date signed 1-5-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1949
BUREAU V. S.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

T

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; STREET ADDRESS (If rural, give location) 2224 Washington Ave. Apt. 102

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Brian	Dean	Couper	1	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White		12-7-48	yrs.		31		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Suburban Hospital, Gen. Rd.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dean Hobart Couper.	Mabel Eleanor Mayhew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	NONE	Mabel Eleanor Couper.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congenital Heart —

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pulmonary Stenosis - Patent Ductus

(c) Interventricular - Patent Foramen Ovale

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertrophied Left & Right Ventricle

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec 7, 1948, to Jan 7, 1949, that I last saw the deceased alive on Jan 6, 1949, and that death occurred at 4:50 A.M., from the causes and on the date stated above.

SIGNATURE W. Joyce M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial-Transit	1-8-49	Littleton, Mass.	Littleton, Mass.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-8-49	H E Jobes	Wm Reuben Pumphrey Funeral Home	Bethesda, Md

RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0609

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Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6310 Conn. Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6310 Conn. Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME FRANCIS DANIEL CRONIN

3. (b) Social Security Number

4. Sex M M
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Francesca Ginechesi
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) JANUARY 17-1898

8. AGE: Years ~~51~~ 51 Months 0 Days 9 If less than one day ..... hrs. ..... min.

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual occupation Government Official
11. Industry or business U.S. Government
FATHER
12. Name John J. Cronin
13. Birthplace Ireland
MOTHER
14. Maiden name Myma Beck
15. Birthplace Sweden
16. Informant Mr. S. Heiner, M.D.
Address 2808 Ordway St. N.W.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29-1949 (month) (day) (year)
Cemetery or crematory Rock Creek
Location Washington D.C.
18. Funeral director Joseph Gawler's Sons
Address 1756 Penn. Ave. N.W.
19. 1-26-49 19 (Date rec'd by registrar) W. E. Jobes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1949, at 2:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948, to Jan. 26 1949
and that I last saw him alive on Jan. 26 1949

Immediate cause of death	DURATION
Respiratory failure	1 day
Due to Sarcoma of left foot	7 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Amputation of left leg — Sarcoma. Date of op. Sept. 1948
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Diener, M.D. M. D. or other
Address 2808 Ordway St. N.W. Wash., D.C. Date signed 1/26/49

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15 9-45-15
#801

RECEIVED
JAN 28 1949
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

9040 0610

CERTIFICATE OF DEATH 186a Reg. Dist. No. 215

M

The correct age

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. is especially important.

I

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; MARYLAND; LENGTH OF STAY (In this place) 11 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY Arlington; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Park Fairfax, Va.; STREET ADDRESS (If rural give location) 3254 Gunston Road

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	FRANCIS	Elizabeth	CRUISE		1	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	White	married	3-5-03	45 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Pottsville, Pa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Crane

14. MOTHER'S MAIDEN NAME: Florence White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Addy Edgar Allen Cruise

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral hemorrhage due to	12 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) fracture of skull (accidental)	1-2-49
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1-8-49 to 1-9-49	Intracerebral Hemorrhage Subdural Hemorrhage	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
Accident	home	Parkfairfax,	Arlington,	Va.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR?
Jan. 2, 1949 5:15 p.m.		fall at home

Deputy Medical Examiner Case

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Frank J. Broschart M.D. (Degree or title) Dep. Med. Exam ADDRESS Gaithersburg Maryland DATE SIGNED 1-14-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-17-49	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
1-14-49	Mary G. Patterson	W. W. Chambers, 1400 Chapin St., N.W. Washington, D.C.

VS. A15

RECEIVED
JAN 18 1949
BUREAU V. S.

0611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450.0

CERTIFICATE OF DEATH

590 Reg. Dist. No. 216

EVIDENCE FOR CORRECTION OF ITEM # 18 IS ON: FILM No. G119 - 3-11-49

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase; LENGTH OF STAY (In this place): 21 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase; STREET ADDRESS (If rural give location): 138 W. Leland

3. NAME OF DECEASED (Type or Print): (First) Jennie (Middle) Ict (Last) Dayhuff

4. DATE OF DEATH: (Month) Jan. (Day) 31 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 10, 1872

9. AGE last birthday: 76 yrs. If under 1 year: Months 2, Days 11; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Calvin Watson

14. MOTHER'S MAIDEN NAME: Sarah Durbin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs. George F. Burns (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerosis Generalized. — Interval Between Onset and Death: 2 days 20 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arthritis Rheumatic — 20 yrs

(c) Hypostatic Congestion — 2-3 days.

Under Nourished.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1949, to Jan 31, 1949, that I last saw the deceased alive on Jan 31, 1949, and that death occurred at 10:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E. K. Fenton M.D. Feb. 1'49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2/3/49 — NAME OF CEMETERY OR CREMATORY: Damascus Cemetery — LOCATION (City, town, or county) (State): Damascus, Md.

DATE REC'D BY LOCAL REG. 2-1-49 — REGISTRAR'S SIGNATURE: W. E. Jobes — 24. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Md.

RECEIVED
FEB 3 1949
BUREAU V. S.

0612

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

204.0
74a

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hrs.

Hospital, institution, or street address where death occurred:
Wash. San + Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New Jersey County Salem Co.

City or town Star Route #2 Salem New Jersey
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME
Dickson, Master Donald Glenn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1943

8. AGE: Years	Months	Days	If less than one day
5	9	27	hrs. min.

9. Birthplace Salem, New Jersey Salem Co
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Raymond E. Dickson.
13. Birthplace New Jersey

MOTHER
14. Maiden name Helen Smith.
15. Birthplace New Jersey

16. Informant Raymond E Dickson.
Address Salem N.J.

17. Burial — Date thereof Jan 7-1949
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist Cemetery

Location Salem N.J. Salem Co.

18. Funeral director J. Arthur Walters
Address 254 Carroll St. Tak. Park

19. Jan 5 1949 J. Wilson Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1949 at 9:22 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-28 1948 to Jan 5 1949 and that I last saw him alive on Jan 4 1949

Immediate cause of death — DURATION
Acute Lymphatic Leukemia — 6 mos.

Due to Massive gastrointestinal — 1 day.

Due to hemorrhage

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE De Voe K. Meade M.D.
M. D. or other

Address Takoma Park 12 Md Date signed 1-5-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1949
BUREAU V. S.

0613

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

450.0 / 97 Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital 8600 Old George Town Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C
STREET ADDRESS (If rural give location) 2316 F Street, N.W.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) E (Last) Dolan
4. DATE OF DEATH (Month) Jan. (Day) 31 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 4, 1882
9. AGE last birthday 67 yrs. If under 1 year Months Days 27 days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Patrick Dolan
14. MOTHER'S MAIDEN NAME Helen Dolan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Daughter (Mrs E. E. McEnnis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — 12 Days.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — 10 years

(c) Secondary Hypertension — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1948, to Jan 31, 1949, that I last saw the deceased alive on Jan 31, 1949, and that death occurred at 9:20 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Kenneth Vaughan M.D. ADDRESS 8252 Georgia Ave Silver Spring Md DATE SIGNED 2/1/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 2-3-49 NAME OF CEMETERY OR CREMATORY Cedar Hill Cem LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 2/1/49 REGISTRAR'S SIGNATURE W. E. Jobes Jr.
24. FUNERAL DIRECTOR James E. Ryan Inc. ADDRESS 317 Pa. Ave. S.E. Wash 3, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 0614

CERTIFICATE OF DEATH 940

Reg. Dist. No. 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Woodfield
LENGTH OF STAY (In this place): 29
HOSPITAL OR INSTITUTION OR STREET ADDRESS: none

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithersburg R.F.D (Woodfield)
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Marian (Middle) Louise (Last) Duvall

4. DATE OF DEATH: (Month) Jan (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct 22 1871

9. AGE last birthday: 77 yrs. If under 1 year: Months. 2 Days 19 If under 24 hrs.: Hours Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Zedarick T. Duvall

14. MOTHER'S MAIDEN NAME: Mary E. Crown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Estella Burdette

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: died suddenly

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep. Med. Exam. Case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 9:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Frank J. Bronnert M.D. Dep. Med. Exam

ADDRESS: Gaithersburg

DATE SIGNED: Maryland

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan 14-1949

NAME OF CEMETERY OR CREMATORY: Wesley Grove and

LOCATION (City, town, or county): Woodfield (State)

DATE REC'D BY LOCAL REG.: Jan. 13, 1949

REGISTRAR'S SIGNATURE: Della V. Burdette

24. FUNERAL DIRECTOR: Roy W Barber

ADDRESS: Laytonsville Md

RECEIVED
JAN 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5501 / 121

0615

Reg. Diat. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 16 days

Hospital, institution, or street address where death occurred:
U S Naval Hospital

How long in hospital or institution? 2mo 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Tacoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Denwood Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: Navy W W 2

3. (a) FULL NAME: EDLUND, Erick James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Arlene Edlund

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 8-22-03

8. AGE: Years	Months	Days	If less than one day
45	9	4	..... hrs. ..... min.

9. Birthplace: Arkansas (Town, county, and state)

10. Usual occupation: Pharmacist

11. Industry or business: Private

FATHER — 12. Name: Erick Edlund

FATHER — 13. Birthplace: Sweden deceased

MOTHER — 14. Maiden name: Aconia Roberts

MOTHER — 15. Birthplace: Alabama living

16. Informant: Wife: Arlene Edlund

Address: 23 Denwood Avenue, Tacoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Virginia

18. Funeral director: J. Arthur Walters By H.M.D.

Address: 254 Carroll St NW Wash. D.C.

19. 1-1- (Date rec'd by registrar) 19 49 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1, January 1949, at 810 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 15 October 1948, to January 1949 and that I last saw him alive on 1 January 1949

	DURATION
Immediate cause of death: Abscess Liver	6wks
Due to: Peritonitis	10wks
Due to: Perforated Appendicitis	10wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Hanner J. M. HANNER CDR MC USN M. D. or other

Address: U S Naval Hospital, Bethesda, MD Date signed 1-1-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

RECEIVED
JAN 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

0616

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
STREET ADDRESS (If rural, give location): 17 Aspen St.

3. NAME OF DECEASED (Type or Print): (First) Katherine (Middle) (Last) Engel

4. DATE OF DEATH: (Month) Jan. (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 4, 1869

9. AGE last birthday: 79 yrs. — If under 1 year: Months: 1, Days: 18, Hours, Min. If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Rack

14. MOTHER'S MAIDEN NAME: Louise Schutte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Charlotte Engel (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinomatosis — Aug '48

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma Pylorus (Stomach) — Oct '47

(c) Hypertensive Cardiovascular — Past 30 yrs.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Disease

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED: While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1947, to Jan 22, 1949, that I last saw the deceased alive on Jan 22, 1949 and that death occurred at 10:55 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Edward W Burch M.D. — ADDRESS: — DATE SIGNED: Jan 22/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — **DATE:** 1/25/49 — **NAME OF CEMETERY OR CREMATORY:** St. Marys — **LOCATION (City, town, or county) (State):** Rockville, Maryland

DATE REC'D BY LOCAL REG.: 1-23-49 — **REGISTRAR'S SIGNATURE:** R E Jones — **24. FUNERAL DIRECTOR:** Robert A. Pumphrey — **ADDRESS:** Bethesda, Md.

RECEIVED
FEB 7 1949
BUREAU V. S.

0617

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

592

CERTIFICATE OF DEATH

61

Reg. Dist. No. 223

1. PLACE OF DEATH · COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park Md. LENGTH OF STAY (in this place): 7 hr 12 hr.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington D.C.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium & Hosp. Takoma Park, Md.	STREET ADDRESS (If rural give location): 1111 - H St. N.W. Annapolis Hotel

3. NAME OF DECEASED (Type or Print)	(First) Joseph	(Middle) No	(Last) Fisher	4. DATE OF DEATH	(Month) January	(Day) 19	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 2-14-1904	9. AGE last birthday: 44 yrs.	If under Months: 4	1 year Days: 5	If under Hours: 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ex - Jeweler	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Helena, Mont.	12. CITIZEN OF WHAT COUNTRY? American				
13. FATHER'S NAME: Myron Fisher	14. MOTHER'S MAIDEN NAME: Jean Lane						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Wash. San & Hosp. records.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	2 wks
Antecedent cause(s)	(b) Acute Exacerbation of Chronic Glomerular Nephritis	5 mos
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Diabetes mellitus	3

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 11, 1949, to Jan 19, 1949, that I last saw the deceased alive on Jan 18, 1949, and that death occurred at 6:22 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
DeVoe K. Meade M.D.		504 Tulip Ave. Takoma Park, Md.	

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Jan 20 49	NAME OF CEMETERY OR CREMATORY: Geo Wash. Mem.	LOCATION (City, town, or county) (State): Hyattsville Md
DATE REC'D BY LOCAL REG.: 1/19/49	REGISTRAR'S SIGNATURE: J. Wilson Dodd	24. FUNERAL DIRECTOR: B Danyansky & Son	ADDRESS: 3501-14th NW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0618

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (In this place) 4 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Home-4603 Harling Lane

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, #; STREET ADDRESS (If rural, give location) 4603 Harling Lane

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) B. (Last) FOGG

4. DATE OF DEATH: (Month) Jan. (Day) 8 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2/10/1876

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-

10b. KIND OF BUSINESS OR INDUSTRY: Accountant

11. BIRTHPLACE (State or foreign country): Cornwall, Canada

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Walter Fogg

14. MOTHER'S MAIDEN NAME: Eliza Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 349-09-3937

17. INFORMANT: Mrs Jennie E. Fogg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) pneumonia - atypical (virus)	2 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) gen. debility - splenomegaly	10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 26 1948 to Jan 8, 1949, that I last saw the deceased alive on Jan 8, 1949, and that death occurred at 1:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John V Dolan M.D. ADDRESS 3100 Conn ave, Wash. DC DATE SIGNED Jan 8 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 1/20/49 | NAME OF CEMETERY OR CREMATORY: Forest Home Cemetery | LOCATION (City, town, or county): Forest Park (State): Ill.

DATE REC'D BY LOCAL REG.: 1/14/49 | REGISTRAR'S SIGNATURE: W. E. Johns

24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Md.

RECEIVED
JAN 15 1949
BUREAU V. S.

Fox
0619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 421.4

CERTIFICATE OF DEATH 920 Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (In this place): 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4805 Hampden Lane

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
STREET ADDRESS (If rural, give location): 4805 Hampden Lane

3. NAME OF DECEASED (Type or Print): (First) Carrie (Middle) Unglaub (Last) Fox

4. DATE OF DEATH: (Month) Jan (Day) 25 (Year) 49 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: May 31, 1879

9. AGE last birthday: 69 yrs. If under 1 year: Months 7 Days 24 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Philip Unglaub

14. MOTHER'S MAIDEN NAME: Mary E. Scharf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yeer, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John R. Fox, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congestive Heart Failure	18 MONTHS
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary Embolization	5 DAYS
	(c) Valvular Heart Disease, Aortic Stenosis	50 YEARS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not releted to the disease or condition causing death.	Arteriosclerosis, general	5 YEARS

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE

PLACE (Home, ferm, factory, street, OF office bldg., etc.) INJURY: — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Dey) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from June 5, 1947, to Jan. 25, 1949, that I last saw the deceased alive on Jan. 24, 1949, and that death occurred at 4:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert G. Angle	M.D.	106 Del Ray Bethesda Md.	Jan. 25, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 28/49	Greenmount Cemetery	Baltimore Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-25-49	W. E. Forbes	Robert A. Pumphrey.	Bethesda, Md.

Query to Dr. OK

VS. A15

RECEIVED
JAN 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0620

334

CERTIFICATE OF DEATH 830

Reg. Dist. No. 218

1. PLACE OF DEATH
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Metropolitan Grove,
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Metropolitan, Grove.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Nathan		Frazier		Jan.	18,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	Colored	Widowed	Mar. 9, 1896	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Laborer		Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sye Frazier	Mary Nolan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.		722-05-4753	Nancy Warren

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia, Broncho	2 days
Antecedent cause(s)	(b) Cerebral Vascular accident	2 mos.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerosis	Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 12 Jan 49, to 18 Jan 49, that I last saw the deceased alive on 18 Jan 49 and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas Landon	M.D.	Damascus, Md.	19 Jan 49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 21, 1949	St. Rose	Cloppers, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 20, 1949	Clorenda G. Cooke	Robert L. Snowden	Rockville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

196 55 b

0621

Reg. Diat. No. 714

1. PLACE OF DEATH:

County: Montgomery County

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, Institution, or street address where death occurred: 1508 - Ballard St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5409 - 36th Avenue,

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Elena Frediani

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	widowed

6.(b) Name of husband or wife: George Frediani

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 30, 1884

8. AGE: Years	Months	Days	If less than one day
64 65			..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: ? Cacherabini

13. Birthplace: Italy

MOTHER — 14. Maiden name: Venturini

15. Birthplace: Italy

16. Informant: Mr. Victor Frediani

Address: 54 Quincy Place, N.E.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/5/49 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery Jan 8, 1949

Location: Washington, D.C.

18. Funeral director: Martin W. Kyrong Co.

Address: 1300 N. St. N.W. Wash. 5, D.C.

19. Jan 5 1949 Josephine M. Schaeffer Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5th 1949 at 1 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1949 to January 5 1949 and that I last saw her alive on January 5 1949

Immediate cause of death	DURATION
Respiratory arrest	instant
Due to: Metastasis to the brain of Fibrosarcoma of the left orbit	1 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ronald J. Fleischer M.D.

M. D. or other

Address: 5401 - 35th Ave. Hyattsville Md. Date signed: 1-5-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 10 1949
BUREAU V. S.

0622

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

42.2.2

50

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville RFD #3
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bachelor Forest Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville R. F. D. #3
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Nellie (Middle) A (Last) Gaither

4. DATE OF DEATH (Month) 1 (Day) 8 (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH Aug. 22, 1877

9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Howard Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Capt. Otis Worthington

14. MOTHER'S MAIDEN NAME Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. C. Leonard Gaither - Rockville RFD #3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Heart Failure — Interval between onset and death: 3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c) Chronic Myocarditis — 6 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12 Nov 48

19b. MAJOR FINDINGS OF OPERATION Carcinoma of left breast.

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Jan, 1949, to 8 Jan, 1949, that I last saw the deceased alive on 8 Jan, 1949, and that death occurred at 9:00 P m., from the causes and on the date stated above.

SIGNATURE Charles H. Fraser (Degree or title) MD ADDRESS Sandy Spring Md DATE SIGNED 8 Jan 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE 1/11/49 — NAME OF CEMETERY OR CREMATORY Loudon Park Cem. — LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REG. 1/10/49 — REGISTRAR'S SIGNATURE R. W. Hedrick Dpty.

24. FUNERAL DIRECTOR WM. J. TICKNER & SONS — ADDRESS Balto., Md.

EVIDENCE FOR CORRECTION OF NAME + ADDITION OF BIRTH PLACE SHOWN ON:

FILM No. G 118 JAN 25 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0623

331

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital 8600 Old Georgetown Rd.	STREET ADDRESS 621 'E' St. N. E. (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Anne ~~Xxxxxx~~ McCall (~~Middle~~) Galleher (Last)			4. DATE OF DEATH (Month) Jan (Day) ~~14~~ 13 (Year) 49 19		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH March 1877	9. AGE last birthday 71 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) BUTLER, KENTUCKY		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME McCall			14. MOTHER'S MAIDEN NAME Pugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage.	11 hrs.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arterio sclerosis.	2+yrs
	(c) Hypertension.	2+yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE OF INJURY (Home, farm, factory, street, office ~~bldg., etc.~~)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1947, to Jan, 1949, that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 11:55 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C A Richwine	MD	5522 Western Ave Ch, Ch Md	14 Jan 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1-17-49	NAME OF CEMETERY OR CREMATORY Arlington Nat.	LOCATION (City, town, or county) Arl.	(State) Va.
DATE REC'D BY LOCAL REG. 1-14-49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR Martin W. Hyong Co	ADDRESS 1300 N. St NW	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 15 1949
BUREAU V. S.

0624

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

592
1318

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) | LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 804 Ingraham St., N.W.

3. NAME OF DECEASED (Type or Print): (First) Everett (Middle) Howard (Last) GASCH
4. DATE OF DEATH: (Month) January (Day) 11 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: W-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 11-24-15
9. AGE last birthday: 33 yrs. If under 1 year: Months. 1 Days 17 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): Ill.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: GASCH, Ernest F.
14. MOTHER'S MAIDEN NAME: MILLER, Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): WWII
16. SOCIAL SECURITY NO.
17. INFORMANT: Father: Mr. Ernest F. Gasch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia	Estimate about 1 month
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Glomerular Nephritis	Estimate 2 yrs.
	(c) Cardiac Hypertrophy	Estimate 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1-9-49
19b. MAJOR FINDINGS OF OPERATION: Ventricular (fap) Decompression
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1949, to Jan 11, 1949, that I last saw the deceased alive on 11 Jan, 1949, and that death occurred at 1:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John C McNerney — ADDRESS — DATE SIGNED 1-11-49

J. C. McNERNEY, Cdr. MC USN — U.S. Naval Hospital, Bethesda, Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE — NAME OF CEMETERY OR CREMATORY: Mount Rose — LOCATION (City, town, or county) (State): Chicago, Ill

DATE REC'D BY LOCAL REG. 1-11-49 — REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR — ADDRESS: W. W. CHAMBERS, 1400 Chapin St., N.W. Washington, D.C.

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B1a 442X

0625

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 12-29-48

Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda Md.

How long in hospital or institution? Since 12-29-48

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3616 Van Ness St
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME John Girault

3.(b) Social Security Number

4. Sex: m

5. Color or race: wh

6.(a) ~~Single~~, married, ~~widowed, or divorced~~

6.(b) Name of husband or wife — Virginia Girault

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec., 10, 1892

8. AGE: Years 56 | Months | Days 17da. | If less than one day ..... hrs. ..... min.

9. Birthplace New Orleans La.
(Town, county, and state)

10. Usual occupation Asst. Director Interstate Commission

11. Industry or business

FATHER
12. Name Walter Girault
13. Birthplace New Orlean La.

MOTHER
14. Maiden name LaSassier Carmelite
15. Birthplace New Orleans La.

16. Informant Virginia M. Girault

Address 3616-Van Ness St. N.W. D.C.

17. Burial Removal Date thereof Jan. 7, 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Metairie

Location New Orleans, La.

18. Funeral director S H Hines Co

Address 2901 14th St N.W.

19. 1-7 1948 W.E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-'49 1949 at 8 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1948 to Jan. 6 1949 and that I last saw him alive on Jan. 5 1949

Immediate cause of death	DURATION
Bronchi-Pneumonia "Terminal"	48 hrs
Due to Cardio-vascular Renal Disease with	7 yrs.
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cardio-vascular-renal disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney Cohansius EX.D. M. D. or other

Address 392 Ingoman St. N.W. Date signed 1-6-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0626

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 1 yr. 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Ala. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sulligent
STREET ADDRESS (If rural give location): Route #2

3. NAME OF DECEASED (Type or Print) (~~First~~) (~~Middle~~) (~~Last~~): GREER, Frances Russell

4. DATE OF DEATH: (Month) January (Day) 10, (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 9-21-18

9. AGE last birthday: 30 yrs. — If under 1 year: Months 3 Days 19 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: RUSSELL, C. A.

14. MOTHER'S MAIDEN NAME: GLASCO, Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: husband: Lt. Charles E. Greer, USN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Sarcoma, retroperitoneal with metastases to Bones, spleen, liver, dura, Kidney, Lymph nodes and Colon	18 Months
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Urethral obstruction due to tumor	3 months
	(c) Cardiac Failure	1 wk

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-29-47 4-15-48 1-19-49 9-2-48

19b. MAJOR FINDINGS OF OPERATION: metastatic tumor of vertebrae

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 12, 1947, to 10 Jan, 1949, that I last saw the deceased alive on 10 Jan, 1949, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): J. C. McNEENEY, Cdr. MC USN
ADDRESS: U.S. Naval Hospital, Bethesda, Md.
DATE SIGNED: 1-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE:
NAME OF CEMETERY OR CREMATORY:
LOCATION (City, town, or county) (State): Caledonia, Miss.

DATE REC'D BY LOCAL REG.: 1-10-49
REGISTRAR'S SIGNATURE: Mary C. Patterson
Mary C. Patterson

24. FUNERAL DIRECTOR: W. W. CHAMBERS
ADDRESS: Georgetown, D.C.

RECEIVED
JAN 14 1949
BUREAU V. S.

0627

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

913.5
170c

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery County
City or town: Takoma Park D.C. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two weeks. 17½ years.
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? Two weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 722 Erie Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: — World War I

3. (a) FULL NAME: Griffee, Mr. Andrew Thomas

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Caucasian	married.

6.(b) Name of husband or wife: Leah M. Griffee
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): August 5, 1886

8. AGE: Years	Months	Days	If less than one day
62	5	0	hrs. min.

9. Birthplace: Madison County, Indiana
(Town, county, and state)
10. Usual occupation: Physical Therapist
11. Industry or business: Washington Sanitarium

FATHER
12. Name: Frank Griffee
13. Birthplace: Indiana

MOTHER
14. Maiden name: Sabilla Griffee (Hicks)
15. Birthplace: Indiana

16. Informant: Mrs. Leah Griffee
Address: 722 Erie Avenue

17. Removal Burial (Burial, cremation, or removal. Which?) Date thereof: JAN. 9, 1949 (month) (day) (year)
Cemetery or crematory: JEFFERSON CEMETERY
Location: HARTFORD CITY, INDIANA.
18. Funeral director: J. Arthur Walters
Address: 234 CARROLL ST. TAKOMA PARK 12, D.C.

19. 1/6 1949 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5, 1949, at 6:13 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22, 1948, to Jan. 5, 1949
and that I last saw him alive on Jan. 5, 1949

Immediate cause of death	DURATION
Cerebral contusion & laceration	2 wks
Due to	
Due to	
Other conditions Broncho-pneumonia	12 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Dec. 22, 1948
Where did injury occur? Takoma Park, (City or town) Montgomery, (County) Md. (State)
Injured at home, farm, industry, public place (where?): near Hospital
Means of injury: hit by auto Injured at work?

23. SIGNATURE: Paul V. Starr, M.D. M. D. or other
Address: Takoma Park, Md. Date signed: 1-5-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Approved
Fred J. Brustad M.D.
Asst Med. Exam
1-5-49

RECEIVED
JAN 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

600.0 93d Reg. Dist. No. 215

hm 0628

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) LENGTH OF STAY (in this place) 2 mons. 28 da	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural give location) 16 17th St., N.E.

3. NAME OF DECEASED (Type or Print) (First) Eli	(Middle) Henry	(Last) GRIFFITH	4. DATE OF DEATH (Month) January	(Day) 16,	(Year) 1949
5. SEX male	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 10-3-71	9. AGE last birthday 77 yrs.	If under 1 year Months 3 Days 13 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Businessman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME GRIFFITH, Tunis		14. MOTHER'S MAIDEN NAME LEIGH, Esther			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	(If year, give war or dates of service) SpAm	16. SOCIAL SECURITY NO.	17. INFORMANT wife: Mrs. Catherine M. Griffith		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchopneumonia, Bilateral

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Pyelonephritis and Arteriosclerotic Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18, 1948, to 1-16, 1949, that I last saw the deceased alive on 1-16-, 1949, and that death occurred at 2:09 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. W. Miller, Jr.	Lt. MC USN	US Naval Hospital, Bethesda, Md.	1-17-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE 1-19-49	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Va.
DATE REC'D BY LOCAL REG. 1-17-49	REGISTRAR'S SIGNATURE Mary C. Patterson	24. FUNERAL DIRECTOR Joseph Gawler Sons, 1756 Penn. Ave., N.W. Wash., D.C.	ADDRESS

7, a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

581.0 .124 b

0629

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda

LENGTH OF STAY (in this place) 1 day 15 hrs 15 min

HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban; Bethesda Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington COUNTY D.C.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural give location) 4024 Calvert St. N.W.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) R (Last) Trillot

4. DATE OF DEATH (Month) 1 (Day) 19 (Year) 1949

5. SEX M.

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Aug. 15 1904

9. AGE last birthday 44 yrs. If under 1 year Months 5 Days 4 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water Works Operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Great Falls Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Douglas Trillot

14. MOTHER'S MAIDEN NAME Lillian Odgow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 578-32-4314

17. INFORMANT Mrs. Pearl Trillot

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Gastric Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cirrhosis of the Liver

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to January 19, 1949, that I last saw the deceased alive on 18 January, 1949, and that death occurred at 1 30 A.M. m., from the causes and on the date stated above.

SIGNATURE S. Richard Bauenfeld MD. (Degree or title) ADDRESS 7345 Wisconsin Ave, Bethesda Md. DATE SIGNED 19 Jan 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 1/22/49

NAME OF CEMETERY OR CREMATORY National Memorial

LOCATION (City, town, or county) (State) Fairfax Co. Virginia

DATE REC'D BY LOCAL REG. 1-20-49

REGISTRAR'S SIGNATURE W.E. Jobes

24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0630

570.5
122 b

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days + 8 hrs.

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3 days + 8 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lulu M. Hamilton

3. (b) Social Security Number

4. Sex: F

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or ~~wife~~ Alexander Hamilton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 28, 1907

8. AGE: Years 41 | Months 2 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Rockville Md. Montgomery Co.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Turner
13. Birthplace Va.

MOTHER
14. Maiden name Lucy Genis
15. Birthplace Md.

16. Informant Alexander Hamilton
Address Dickerson, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan. 7, 1949
(month) (day) (year)

Cemetery or crematory Selman

Location Selman, Md.

18. Funeral director Robert L. Snowden
Address Rockville, Md.

19. 1-6 1949 (Date rec'd by registrar) W.E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1949, at 5 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1949 19 , to Jan 4, 1949 and that I last saw her alive on Jan 4, 1949

Immediate cause of death Intestinal Obstruction

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. Boyland, M.D.
M. D. or other

Address Suburban Hosp. Date signed 1-4-49

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

175x 49a 0631

Reg. Dist. No. 215

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (in this place) 55 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince Georges; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Landover Hills; STREET ADDRESS (If rural give location) 7105 Webster Street

3. NAME OF DECEASED (Type or Print): (First) Edith (Middle) Jockwill (Last) Hands

4. DATE OF DEATH: (Month) January (Day) 29 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 8-5-82

9. AGE last birthday: 66 yrs. If under 1 year: Months 5 Days 24 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Dent Hancock

14. MOTHER'S MAIDEN NAME: ? Charlotte ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: husband son: Mr. Lester A. Hands

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinoma of ovary (Papillary Serous Cystadeno)	unknown
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-28-48

19b. MAJOR FINDINGS OF OPERATION: Extensive involvement all abdominal vescera

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 5, 1948, to Jan. 29, 1949, that I last saw the deceased alive on Jan. 29, 1949, and that death occurred at 8:42 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Peterson
PAUL PETERSON, Capt. MC USN, US Naval Hospital, Bethesda, Md. 1-29-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 2-1-49 | NAME OF CEMETERY OR CREMATORY: Mt. Olivet | LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG. 1-29-49 | REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR ADDRESS: Deal Funeral Home, 4812 Georgia Ave, NW

RECEIVED
FEB 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0632

447

97

Reg. Dist. No. 314

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 9015 Old Bladensburg Road Silver Spring, Md; LENGTH OF STAY (In this place) 83 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring Md; STREET ADDRESS (If rural, give location) 9015 Old Bladensburg Road.

3. NAME OF DECEASED (Type or Print): (First) ELIZA (Middle) NOLEN (Last) HARDESTY. Eliza Nolen (GIDDINGS) HARDESTY

4. DATE OF DEATH: (Month) JAN (Day) 14 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWED

8. DATE OF BIRTH: JUNE 4 1865

9. AGE last birthday: 83 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND SILVER SPRING, MONTGOMERY CO

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: FRANCIS GIDDINGS

14. MOTHER'S MAIDEN NAME: MARY ANN BEALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: DAUGHTER — RUBY MAE HARDESTY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) PNEUMONIA - HYPOSTATIC	36 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) HYPER TENSION	5 YEARS
	(c) ARTERIO-SCLEROSIS	10 YEARS.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	SENILITY	18 YEARS

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from FEB ..., 1945, to JAN 14, 1949, that I last saw the deceased alive on JAN 8, 1949, and that death occurred at 5:45 P m., from the causes and on the date stated above.

SIGNATURE C. W. Mitchell (Degree or title) M.D ADDRESS Silver Spring, Md DATE SIGNED Jan 14, '49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 1/17/49 | NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetary | LOCATION (City, town, or county) (State): Washington D.C.

DATE REC'D BY LOCAL REG.: Jan. 16, 1949 | REGISTRAR'S SIGNATURE: Josephine M. Schaffer

24. FUNERAL DIRECTOR: Warner E. Pumphrey ADDRESS: Silver Spring Md.

RECEIVED
JAN 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

331 83a 0633

Reg. Dist. No. 716

1. PLACE OF DEATH
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural give location) RR #3

3. NAME OF DECEASED (Type or Print) (First) Blanche (Middle) (Last) Hargett

4. DATE OF DEATH (Month) Jan (Day) 26 (Year) 1949

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH Mar 19 1897

9. AGE last birthday 51 yrs. If under 1 year Months 10 Days 7 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Gaithersburg, md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Thomas E. Mills

14. MOTHER'S MAIDEN NAME Mamie V. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Daughter (Mrs. Lillian Beall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CEREBRO-VASCULAR ACCIDENT	48 HRS
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) HYPERTENSION	3 YRS
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN 24, 1949 to JAN 26, 1949 that I last saw the deceased alive on JAN 26, 1949 and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Ira W Pearlman M.D. for ORG. B. QUEEN Suburban Hosp Bethesda 1-27-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ Burial DATE 1-29-49 NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery LOCATION (City, town, or county) (State) Gaithersburg, Maryland

DATE REC'D BY LOCAL REG. 1-27-49 REGISTRAR'S SIGNATURE W. E. Jobes

24. FUNERAL DIRECTOR ADDRESS M. R. Etchison and Son Frederick, Md.

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

RECEIVED
JAN 31 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0634

420.1

CERTIFICATE OF DEATH

940 Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Commerce Lane

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE DC COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 310 Emerson St N.W.

3. NAME OF DECEASED (Type or Print) (First) Walter (Middle) Patrick (Last) Harlow

4. DATE OF DEATH (Month) Jan (Day) 12 (Year) 1949

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Dec 12 1875
9. AGE last birthday 74 yrs. If under 1 year Months 0 Days 14 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) real estate
10b. KIND OF BUSINESS OR INDUSTRY general
11. BIRTHPLACE (State or foreign country) Wash. DC
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Richard Harlow
14. MOTHER'S MAIDEN NAME Mary Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Jos. W. Harlow

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: died suddenly

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Def. Med. Exam Case 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 5:00 P m., from the causes and on the date stated above.

SIGNATURE Frank J. Broschart (Degree or title) Def. Med. Exam
ADDRESS Gaithersburg
DATE SIGNED Mcf

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE Jan 12-1949
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) Wash. D.C. (State)

DATE REC'D BY LOCAL REG. Jan. 12th 1949
REGISTRAR'S SIGNATURE Mrs. E. P. Thompson per Floyd S. Moxly

24. FUNERAL DIRECTOR W. W. Chambers Co
ADDRESS 1400 Chapin St NW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0635

Reg. Diat. No. 215

EVIDENCE FOR ADDITION ITEM #21 IS ON:

FILM No. G 119 MAR 10 1949

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
U.S.Naval Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Dist Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 911 First Street NW
(If rural, give LOCATION)
2.(a) If veteran, name war W.W.1

3. (a) FULL NAME HARRINGTON, William "J"

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married (Separated)
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-24-1900
8. AGE: Years 48 Months 7 Days 7 If less than one day hrs. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Stean Fitter
11. Industry or business
FATHER 12. Name John Harrington
13. Birthplace Virginia deceased
MOTHER 14. Maiden name Agenes Sweeney
15. Birthplace Virginia living
16. Informant Sister: Eleanor H. Sweeney
Address 911 First Street NW Wash DC
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-6-48 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Virginia
18. Funeral director Timothy Hanlon T. J. H.
Address 641 H Street NE Wash. DC
19. 1-1-49 (Date rec'd by registrar) 19 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 January 1949, at 230A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 December 1948, to 1 January 1949 and that I last saw him alive on 1 January 1949

Immediate cause of death	DURATION
Abscess, Multiple, Left Lower lobe	
Due to Primary Carcinoma, Left Main	3 Mo.
Due to bronchus [3/10/49 ahw]	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Queen
W.F.QUEEN CDR MC USN
M. D. or other
Address U S Naval Hospital Bethesda, Maryland Date signed 1-1-49

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 5 1949
BUREAU V. S.

0636

153

46 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney — LENGTH OF STAY (in this place) 5 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Jacob (Middle) Turner (Last) Hayes				4. DATE OF DEATH (Month) January (Day) 8 (Year) 1949			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married.	8. DATE OF BIRTH March 12, 1870	9. AGE last birthday 78 yrs.	If under Months	1 year Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Hayes			14. MOTHER'S MAIDEN NAME Maria — Hayes				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital record.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia following operation	2 days.
Antecedent cause(s)	(b) Intestinal Obstruction	8 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Adenocarcinoma of Sigmoid Colon	8 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Jan. 6, 1949	19b. MAJOR FINDINGS OF OPERATION Distended bowel, occluding annular Ca of sigmoid c local metastases	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE) —	
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan. 3, 1949, to Jan. 8, 1949, that I last saw the deceased alive on Jan. 8, 1949, and that death occurred at 8:11 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. H. Sigon,	MD.	Sandy Spring, Maryland.	1/8/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE Jan 8-49 Removal	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) Washington D.C.
DATE REC'D BY LOCAL REG. Jan 8-49	REGISTRAR'S SIGNATURE Gertrude B Lawler	24. FUNERAL DIRECTOR Frazier's Funeral Home	ADDRESS 389 K. el. Cat. N.W. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
FEB 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

525 0637

CERTIFICATE OF DEATH 1143

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): 6440 Barnaby St., N. W.

3. NAME OF DECEASED (Type or Print): (First) Frederick (Middle) William L. (Last) HILL

4. DATE OF DEATH: (Month) January (Day) 12 (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 8-27-93

9. AGE last birthday: 55 yrs. If under 1 year: Months. 4 Days 15 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Potomac Electric Power Co.

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: HILL, Frederick William

14. MOTHER'S MAIDEN NAME: WILLIAMS, Jessie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If year, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Aggnes Hill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Pulmonary fibrosis + atelectasis

(c) Pulmonary Cystic Disease (advanced)

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1949, to 12 Jan, 1949, that I last saw the deceased alive on 12 Jan, 1949, and that death occurred at 5:05 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): D E Billman Jg MC USN — ADDRESS: U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 1-12-49

D. E. BILLMAN, Lt. JG MC USN

23. BURIAL, CREMATION, REMOVAL (Specify): burial — DATE: 1-14-49 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 1-12-49 — REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR: S. H. HINES — ADDRESS: 2901 14th St., N.W., Wash., D.C.

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

273 64

0638

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montg. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place) 4 mo —
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boyds Crural 1
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) George (Middle) David (Last) Hillard

4. DATE OF DEATH (Month) Jan (Day) 9 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Sept 10/48

9. AGE last birthday yrs. If under 1 year: Months 4, Days 0; If under 24 hrs.: Hours 0, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Boyds Md

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME George Thomas Hillard

14. MOTHER'S MAIDEN NAME Katheryn Breedon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT George T. Hillard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Status Thymicolymphaticus

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep Med. Exam case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 2:00 A.m., from the causes and on the date stated above.

SIGNATURE Frank J. Broschart M.D. (Degree or title) Dep Med. Exam. ADDRESS Gaithersburg Maryland DATE SIGNED 1-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1/11/49 NAME OF CEMETERY OR CREMATORY Boyds Cemetery LOCATION (City, town, or county) Boyds Md (State)

DATE REC'D BY LOCAL REG. Jan 10/49 REGISTRAR'S SIGNATURE Alsuda G. Cooke

24. FUNERAL DIRECTOR Ernest C. Gaithersburg ADDRESS Gaithersburg Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 12 1949
BUREAU V. S.

0639

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

204.1 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE S. C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (In this place) 3 mons. 26 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Yamassee,
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural give location) Box 582

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Thomas	HILTON	January 26 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	W-US	married	6-11-16	32 yrs.	7 / 15	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Navy	Navy	S.C.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HILTON, Thomas	SMALL, Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWII		wife: Mrs. Gladys C. Hilton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subarachnoid hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Luekemia (Myelogenous)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 30 Sept., 1949, to 26 Jan., 1949, that I last saw the deceased alive on 26 Jan., 1949, and that death occurred at 11:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L. M. POPE	Cdr. MC USN	US Naval Hospital, Bethesda, Md.	1-26-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-29-49	Yemassee Cemetery	Yamassee, S.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-26-49	Mary C. Patterson	W. W. CHAMBERS,	1400 Chapin St., N.W. Wash., D.C.

T.C.

RECEIVED
JAN 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

180
52a
new no 0640

Reg. Dist. No. 215

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo 14 days

Hospital, institution, or street address where death occurred: U S Naval Hospital

How long in hospital or institution? 4 mo 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Arlington

City or town Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 811 N. Greenbrier Street
(If rural, give LOCATION)

2.(a) If veteran, name war Army W W 2

3. (a) FULL NAME HOLLOWAY, William Leavelle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Susan G. Holloway

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 21 July, 1900

8. AGE: Years	Months	Days	If less than one day
48	5	10	..... hrs. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Warehouse Manager

11. Industry or business

FATHER
12. Name Robert E. Holloway
13. Birthplace Virginia living

MOTHER
14. Maiden name Ida Leavelle
15. Birthplace Virginia living

16. Informant Wife: Susan G. Holloway

Address 811 N. Greenbrier St Arlington VA

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1-5-49 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

16. Funeral director W. W. Chambers A Binson

Address 3072 M Street NW Wash, DC

19. 1-1-49 19 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 January 1949 at 935A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 August 1948, to 1 January 1949 and that I last saw him alive on 1 January 1949

Immediate cause of death Bronchopneumonia Bilateral

Due to Hypernephroma, rt. kidney Cheetostasis to liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. MILLER JR. LT MC USN
M. D. or other

Address U S Naval Hospital Bethesda, Maryland Date signed 1-1-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 5 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0641

422.1

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
COUNTY Montgomery
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Waverley Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Ohio
COUNTY Licking
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Holton King (Last) Hollyday

4. DATE OF DEATH (Month) Jan. (Day) 23, (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Feb. 22, 1867

9. AGE last birthday 81 yrs. If under 1 year Months 11 Days 1 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Newark, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Oren G. King

14. MOTHER'S MAIDEN NAME Bianca Holton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If year, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Richard C. Hollyday

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic myocardial insufficiency — Interval between onset and death: 6 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-sclerosis — 3 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mch. 19, 1948, to Jan. 23, 1949, that I last saw the deceased alive on Jan 23, 1949, and that death occurred at 5-30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wheeler D. Huff ADDRESS Bethesda, Maryland DATE SIGNED Jan 25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 1/26/49

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. 1-26-49

REGISTRAR'S SIGNATURE W. E. Jobes

24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 28 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157
46g

0642

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Potomac
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Potomac
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.# 3 Bethesda
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME William Elmer Houser

3. (b) Social Security Number yes-Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Adelia Houser

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) June 8,1869

8. AGE:	Years	Months	Days	If less than one day
79	79	6	28	hrs. min.

9. Birthplace Montgomery Co. Maryland
(Town, county, and state)

10. Usual occupation Wholesale Grocery Salesman

11. Industry or business Wholesale Grocery

FATHER
12. Name Phillip D. Houser
13. Birthplace Maryland

MOTHER
14. Maiden name Harriot Boroughs
15. Birthplace Maryland

16. Informant Mrs Irene Cottingham

Address R.F.D.#3 Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8,1949 (month) (day) (year)

Cemetery or crematory Potomac Church Cemetery

Location Potomac, Maryland

18. Funeral director Wm. Reuben Pumphrey Funeral Home

Address Bethesda, Maryland

19. 1-7 1949 (Date rec'd by registrar) W. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 January 1949 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 6 19 , to Jan 6 1949 and that I last saw him alive on 4 Jan 1949

Immediate cause of death	DURATION
Carcinomatosis	2 mons
Due to Carcinoma Pancreas	1 year
Due to	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Head of Pancreas Date of op. Oct 48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Humphrey Md M. D. or other

Address Rockville Md Date signed 6 Jan 49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU T. S.

EVIDENCE FOR ADDITION IN #18a IS ON!

FILM No. G 119 MAR -7 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

162 472

0643

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
COUNTY Montgomery
STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda rural
LENGTH OF STAY (in this place) 3 mons. 10 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D. C.
STREET ADDRESS (If rural give location) 931 Longfellow St., N.W.

3. NAME OF DECEASED (Type or Print) (First) Charles Sidney (Middle) HUNT (Last)

4. DATE OF DEATH (Month) January (Day) 18 (Year) 1949

5. SEX male

6. COLOR OR RACE W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH 1-29-07

9. AGE last birthday 41 yrs. If under 1 year Months 11 Days 19 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Canada

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME HUNT, Charles

14. MOTHER'S MAIDEN NAME VAN CAMP, Lela

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If year, give war or dates of service) WWI & II

16. SOCIAL SECURITY No.

17. INFORMANT wife: Mrs. Dena Hunt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchogenic Carcinoma Primary

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10-18-48

19b. MAJOR FINDINGS OF OPERATION Tumor, left cerebral hemisphere

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 8, 1948, to Jan. 18, 1949, that I last saw the deceased alive on Jan. 18, 1949, and that death occurred at 4:47 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. C. Mc NERNEY, Cdr. MC USN, US Naval Hospital, Bethesda, Md. 1-19-49

23. BURIAL, CREMATION REMOVAL (Specify) burial

DATE 1-24-49

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. 1-19-49

REGISTRAR'S SIGNATURE Mary C. Patterson

24. FUNERAL DIRECTOR S. H. HINES & Bro. ADDRESS 14th St., N.W., Wash., D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 20 1949
BUREAU V. S.

0644

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.0 / 93d

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1011 H St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME
HUNTER, William Byrne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Ruth Hunter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 14, 1893

8. AGE:

Years	Months	Days	If less than one day
55	6	21	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business

FATHER
12. Name: HUNTER, William B.
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: O'CONNEL, Catherine B.
15. Birthplace: Washington, D.C.

16. Informant: wife: Mrs. Ruth Hunter
Address: 1011 H St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-8-49 (month) (day) (year)

Cemetery or crematory: CEdar Hill Cemetery

Location: Washington, D. C.

18. Funeral director: Lee Funeral Home
Address: 4th & Mass., Ave., N.E., Wash., D.C.

19. 1-6- 1949 (Date rec'd by registrar) Mary C. Patterson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 January 1949 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 December 1948 to 5 January 1949 and that I last saw him alive on 5 January 1949

Immediate cause of death: Coronary Heart Disease, artexiosclerotic — DURATION: 2 yrs

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Queen
Wm. F. QUEEN, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-6-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU V. S.

0645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

420.1
93d

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takome Park — LENGTH OF STAY (in this place) 13 hrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium	STREET ADDRESS (If rural give location) 24 Crittenden St., N.E.

3. NAME OF DECEASED (Type or Print) (First) MELVIN (Middle) LAWRENCE (Last) HURLEY				4. DATE OF DEATH (Month) JANUARY (Day) 21 (Year) 1949	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 30/1906	9. AGE last birthday 42 yrs.	If under 1 year Months / Days / If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY H.J.Heinz Co.	11. BIRTHPLACE (State or foreign country) Hyattsville, Md.	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Francis Hurley			14. MOTHER'S MAIDEN NAME Mary E. Auld		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 577-07-1172	17. INFORMANT Mrs. Jewell E. Hurley (Wife)		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 14 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Essential hypertension

(c) Hypertensive Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 11, 1947, to Jan. 21, 1949, that I last saw the deceased alive on Jan. 20, 1949, and that death occurred at 2:10 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Henryan Lowden	M.D	1603 19th ST. N.W., Washington, D.C.	1-21-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Jan 24 1949	NAME OF CEMETERY OR CREMATORY Mt Olivet	LOCATION (City, town, or county) Washington D.C. (State)
DATE REC'D BY LOCAL REG. Jan. 21-1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR S.H. Hines Co.	ADDRESS 2901-14th St. NW. DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0646

7544

157

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)	LENGTH OF STAY (In this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
	STREET ADDRESS (If rural give location) 1724 17th St., N. W. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Rhea	HUTCHERSON, Jr.	January 13 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
male	White	single	November 1, 1948	yrs.	2	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Bethesda, Md.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HUTCHERSON, James R.	BURCHFIELD, Mildred

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no			Father: James Hutcherson, Sr.,

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Congenital Anomaly, Atresia aortic orifice of heart; Pulmonary edema	2 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 8, 1949, to Jan 13, 1949, that I last saw the deceased alive on 13 Jan, 1949, and that death occurred at 6:41 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James T. FOWLER, Jr., Cdr. MC USN US Naval Hospital, Bethesda, Md. 1-13-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-17-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-13-49	Mary C. Patterson	W. W. CHAMBERS,	1400 Chapin St., N.W. Washington, D.C.

RECEIVED
JAN 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0647

152
462

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant to give residence of mother)
State: Md. County: Montgomery
City or town: Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: BIRDIE ROYNON JOHNSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry B. Johnson
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 18, 1875

8. AGE: Years	Months	Days	If less than one day
73			hrs. ... min.

9. Birthplace: Tenn. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ---

FATHER
12. Name: Roynon
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Martha Razille
15. Birthplace: Tenn.

16. Informant: Mr. Henry B. Johnson
Address: Cabin John, Md.

17. ✓ (Burial, cremation, or removal. Which?) Date thereof 1/25/49 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Washington D.C.
19. Funeral director: Cheney Chase Funeral Home
Address: 5103 Wis. Ave., N.W., Washington, D.C.

19. 1/22/49 (Date rec'd by registrar) W. C. Jones, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1949 at 11 15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1947 to Jan 23 1949 and that I last saw h... alive on Jan 23rd 1949

Immediate cause of death	DURATION
Carcinoma of Jejunum	2 years
Due to: with Metastases	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bradley D. Hodgkins MD (M. D. or other)
Address: 313 W. Bradley Lane Date signed: 1/23/49

RECEIVED
JAN 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 443 0648

CERTIFICATE OF DEATH 932 Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 33 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Houston	Johnston	January	24	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Caue.	Widower	May 26, 1871	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Walker Johnston
14. MOTHER'S MAIDEN NAME: Eliza Morrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Washington Sanitarium Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive Cardiac Failure	Terminal
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	Years
	(c) Arteriosclerosis	Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Uremic State	

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 27, 1948, to Jan 24, 1949, that I last saw the deceased alive on Jan 23, 1949, and that death occurred at 3:15 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert A Hare	M.D.	Takoma Park, Md.	1/24/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Jan. 24, 1949	Unk.	McConnellsburg, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/24/49	J Milton Dodd	Robert A. Pumphrey	7557 Wisc. Ave. Bethesda, Md.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1
94a

0649

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9502 Columbia Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME George A. Jones George Alfred Jones

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wh.	Mar ried

6.(b) Name of husband or wife Lottie G.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1860

8. AGE:

Years	Months	Days	If less than one day
88	1	23	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Frank Jones
13. Birthplace Wash., D.C.

MOTHER
14. Maiden name Margrett Ann Landon
15. Birthplace Md.

16. Informant Mrs. Lottie G. Jones

Address 9502 Columbia Blvd., Sil. Spg., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1949 (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D. C.

18. Funeral director Warner E. Pumphrey, Inc

Address Silver Spring, Md.

19. Jan 3 1949 (Date rec'd by registrar) Josephine M. Schoeffler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1949, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948, to Jan 1 1949 and that I last saw him alive on Dec. 1948

Immediate cause of death Coronary Occlusion

DURATION 2-3 mins

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. S. Rogers, M.D. M. D. or other

Address 9601 Sutton Rd., Silver Spring, Md. Date signed Jan 2, 49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0650

Reg. Dist. No. 215

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bradbury Heights
STREET ADDRESS (If rural give location): 5108 T St., S.E.

3. NAME OF DECEASED (Type or Print) First	Middle	Last	4. DATE OF DEATH (Month) (Day) (Year)
Kenneth	Creighton	JOSE	January 31 19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	11-27-20	58 yrs.	2	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer	McArdle Printing Co.	Mass.	US

13. FATHER'S NAME: JOSE, John
14. MOTHER'S MAIDEN NAME: SMITH, Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWI		wife: Mrs. Audrey I. Jose

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Meningitis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Lobar Pneumonia (Friedlanders)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 17 Jan., 1949, to 31 Jan., 1949, that I last saw the deceased alive on 31 Jan., 1949 and that death occurred at 6:25 P m., from the causes and on the date stated above.

SIGNATURE D E Billman Lt USN (Degree or title) — ADDRESS — DATE SIGNED

D. E. BILLMAN, Lt. JG MC USN, US Naval Hospital, Bethesda, Md. 2-1-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	2-4-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
2-1-49	Mary C. Patterson	W. W. CHAMBERS, 517 11thSt., S.E., Wash., D.C.

J.J. Mc.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 3 1949
BUREAU V. S.

EVIDENCE FOR ADDITION OF INFO. ITEM # 9 SHOWN ON

FILM No. G 118 JAN 21 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450.0 0651

CERTIFICATE OF DEATH

107 Reg. Dist. No. 215

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 8 mons. 18 d.
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 2710 2nd St., S.E.

3. NAME OF DECEASED (Type or Print): (First) Philip (Middle) Bogan (Last) KEEFER
4. DATE OF DEATH: (Month) 1 (Day) 15 (Year) 1949
5. SEX: male
6. COLOR OR RACE: W-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIVORCED
8. DATE OF BIRTH: 9-4-75
9. AGE last birthday: 73 yrs. If under 1 year: Months 4 Days 11 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: KEEFER, Phillip
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): Sp.Am.
16. SOCIAL SECURITY NO.
17. INFORMANT: son: Mr. Philip C. Keefer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchopneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis and Cardiac Insufficiency 8

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 27, 1948, to Jan 14, 1949, that I last saw the deceased alive on Jan 14, 1949, and that death occurred at 8:48 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wm. W. Miller Jr. Lt. MC USN, US Naval Hospital, Bethesda, Md. 1-15-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE: 1-18-49
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG.: 1-15-49
REGISTRAR'S SIGNATURE: Mary C. Patterson
24. FUNERAL DIRECTOR: S.H. Hines Co. 2901 14th St. N.W. Wash. D.C.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 18 1949
BUREAU V. S.

0652

420.1
930

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barnesville
LENGTH OF STAY (in this place) 40 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barnesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Herbert (Middle) Victor (Last) Kessler
4. DATE OF DEATH: (Month) Jan (Day) 15 (Year) 1949

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 7/23/1873
9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. Kessler
14. MOTHER'S MAIDEN NAME: Lucy Cromwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Mary Kessler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive heart failure	8 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary insufficiency	unknown
	(c) Arteriosclerosis	"

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. "

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): neither
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 Jan., 1949, to 14 Jan., 1949, that I last saw the deceased alive on 14 Jan., 1949, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John Fawcett M.D. P.O. Boyds, Md 15 Jan 49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 1/17/49
NAME OF CEMETERY OR CREMATORY: St Mary's
LOCATION (City, town, or county) (State): Barnesville Md

DATE REC'D BY LOCAL REG. 1/16/49
REGISTRAR'S SIGNATURE: Mrs. C. C. Hilton by Mrs. C.B.N.
24. FUNERAL DIRECTOR: William B Hilton ADDRESS: Barnesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 21 1949
BUREAU T. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0653

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) — LENGTH OF STAY (In this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural, give location): RFD #5,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Robert	Paul	KOINER	January	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	single	6-21-18	30 yrs.	7	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Merchant	Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
KOINER, Garnet	SCHERRER, Mary C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes WWII		sister: Miss Edith A. Koiner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Arrythmia, Auricular Fibrillation, Lab #212	45 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Tuberculosis Pulmonary, Reinfection,	
	(c) Active, Far Advanced #1135	3 mos

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 15 Jan, 1949, to 23 Jan, 1949, that I last saw the deceased alive on 23 Jan, 1949, and that death occurred at 5:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John W. Flynn J. W. FLYNN, Lt. JG MC USN	US Naval Hospital, Bethesda, Md.	1-24-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-26-49	St. Mary's	Rockville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-24-49	Mary E. Patterson Mary E. Patterson	Robert A. Pumphrey,	7557 Wis. Ave., Bethesda, Md.

RECEIVED
JAN 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161
47a

0654

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9013 - 2nd Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ALFRED J. LaCROIX

3.(b) Social Security Number: 579-03-8901

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: MARRIED

6.(b) Name of husband or wife: Elizabeth Jane La Croix

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): March 17 1879

8. AGE: Years 69 | Months 9 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace: Fall River, Mass.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Contractor

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. F.H. Burrows.
Address: 4030 Calvert St. N.W. Wash. DC

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jan 15, 1949 (month) (day) (year)

Cemetery or crematory: Mt Olivet Cemetery

Location: Washington D.C.

18. Funeral director: S. H. Hines CO.
Address: 2901 - 14th St., N.W. D.C.

19. June 13 1949 Josephine M Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1949, at 1:40 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8, 1949, to Jan. 13, 1949 and that I last saw him alive on Jan. 8, 1949

Immediate cause of death: Extensive Carcinoma of Larynx involving tonsils and Base of Tongue.

DURATION: over 9 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Warren D. Bull, M.D.
M. D. or other

Address: 2601 - 16th St. N.W. Wash. D.C.

Date signed: Jan. 13, 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0655

CERTIFICATE OF DEATH

443/93d

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7108 Clarendon Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Estelle Perry Lee

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Henry Lee

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 14,1871

8. AGE:	Years	Months	Days	If less than one day
77	77	4	23	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER

12. Name Richard O. Perry

13. Birthplace Maryland

MOTHER

14. Maiden name Margaret B. Waters

15. Birthplace Maryland

16. Informant Mrs Howard Griffith

Address 7108 Clarendon Rd.Bethesda,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 9,1949 (month) (day) (year)

Cemetery or crematory Monocacy Cemetery

Location Beallsville, Maryland

18. Funeral director Wm Reuben Humphrey Funeral Home

Address Bethesda, Md.

19. 1/6 (Date rec'd by registrar) 1949 M E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Janurary 7 1949 at 12:00 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1949 to Jan 7, 1949

and that I last saw h[illegible] alive on Jan 7 1949

Immediate cause of death Pulmonary edema — DURATION 3 days

Due to Chr hypertensive heart disease. — 10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Bauersfeld, M. D. M. D. or other

Address Bethesda, Md Date signed 1/7/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND

~~Department of Commerce~~
~~Bureau of the Census~~

CERTIFICATE OF DEATH

~~COMMONWEALTH OF VIRGINIA~~
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

State Dept of Health

State File No. 0656

443 131 b

Registered No. 216

1. PLACE OF DEATH

(a) County Montgomery — Registration district No. (For reg. use)

(b) Magisterial district

(c) City or town West Haven Md.

(d) Name of hospital or institution 0

(e) Length of stay in hosp. or inst. 0 In this community 2 yrs (Specify whether years, months, or days)

(f) Is place of death within corporate limits?

2. USUAL RESIDENCE OF DECEASED

(a) State Maryland

(b) County Montgomery

(c) City or town W. Haven Street No.

(d) Is place of residence within corporate limits?

(e) Citizen of foreign country? NO (Yes or No)

If Yes, name country

3. (a) FULL NAME George Aaron Lilly

3. (b) If veteran, name war

3. (c) Social security number (Answer only if card is available)

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, divorced. married

6. (b) Name of husband or wife Eara Bower lily

7. Date of birth of deceased Aug. 12 (Month by name) 1887 (Day) (Year)

8. Age: Years 61 Months 4 Days 26 If less than one day hours min.

9. Birthplace Nakomis (City, town, or county) ILL. (State or foreign country)

10. Usual occupation Trade Assn. Execution

11. Industry or business Trade

Father: 12. Name Walter H. Lilly
13. Birthplace Baltimore (City, town, or county) Md (State or foreign country)

Mother: 14. Maiden name Almira J. Smith
15. Birthplace ? (City, town or county) Michigan (State or foreign country)

16. (a) Informant's own signature Walter H. Lilly II.
(b) Address 5506 Worthington Drive N.W.

17. (a) Burial, cremation, or removal? Cremation
(b) Place Cedar Hill Cem. Date 1-8-49 (Month by name) (Day) (Year)

18. (c) Signature of funeral director Jos. Gawler Sons Inc
(b) Address 1756 Penn. Ave. N.W. D.C.

19. (a) Filed 1-8-49 (Date received by reg.) (b) W.E. Jobes (Local, deputy, or sub-registrar's own signature)

MEDICAL CERTIFICATION

20. Date of death January (Month by name) 8 (Day) 1949 (Year) at 1:50 P M (Hour)

21. I hereby certify that I attended the deceased from January 6 1949, to Jan 8 1949; that I last saw him alive on Jan 8 1949; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation — Duration 4 mos

Due to Hypertension and Chronic Glomerulonephritis — 12 yrs.

Due to

Other conditions 0. (Include pregnancy within 3 months of death)

Name of operation 0

Date of operation 0 Major findings: (a) of operations

(b) of autopsy 0

Physician — Underline the primary cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0 (Specify type of place) While at work? 0

(e) Means of injury

23. Signature D Bratney Miller M. D., ~~Cor., or other~~

Address 1834 Eye St NW - Date signed 1-8-49

Form V. S. 12

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

60M

RECEIVED
JAN 11 1949
BUREAU V. S.

0657

EVIDENCE FOR CHARGE OF RACE IS ON: FILM No. G 118 FEB -2 1949

410 X 924

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (in this place) mo. + 3 da's; HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D. C.; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural, give location) 1845 Ingleside Terrace N.W.

3. NAME OF DECEASED (Type or Print): (First) Ethel (Middle) (Last) Lloyd

4. DATE OF DEATH: (Month) (Day) 19 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Aug 29 1877

9. AGE last birthday: 71 yrs. If under 1 year: Months 5 Days 20; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S. of N. Amer.

13. FATHER'S NAME: George H. Mailrer

14. MOTHER'S MAIDEN NAME: Henrietta Wicker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure; Bronchopneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rheumatic Heart Disease (mitral + aortic stenosis) (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1944, to Jan., 1949, that I last saw the deceased alive on 18 January, 1949, and that death occurred at 5:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

S. Richard Rosenfeld M.D. 7345 Wisconsin Ave Bethesda Md. 1/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Cremation; DATE: 1-20-49; NAME OF CEMETERY OR CREMATORY: Cedar Hill; LOCATION (City, town, or county) (State): Suitland, Prince George, Md.

DATE REC'D BY LOCAL REG. 1-20-49

REGISTRAR'S SIGNATURE: V. E. Jones

24. FUNERAL DIRECTOR ADDRESS: Robert A. Dunphrey, Bethesda, Md.

VS-A15

RECEIVED
JAN 24 1949
BUREAU V. S.

0658

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 192

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

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VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D. C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): 622 Atlantic St., S.E.

3. NAME OF DECEASED (Type or Print): (First) Douglas (Middle) Clyde (Last) Mac KENZIE

4. DATE OF DEATH: (Month) January (Day) 17 (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 10-19-97

9. AGE last birthday: 51 yrs. If under 1 year: Months 2 Days 28 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Maker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: MacKENZIE, Henry

14. MOTHER'S MAIDEN NAME: FARQUAHARSON, Margrette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yesWWI
(If year, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Lessie MacKenzie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Brain Tumor (Astrocytoma)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Bronchopneumonia, bilateral

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED Whlie at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 9, 1949, to Jan 17, 1949, that I last saw the deceased alive on Jan 17, 1949, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE: Wade H. Boswell
(Degree or title): R. H. BOSWELL, Lt. MC USN
ADDRESS: U. S. Naval Hospital, Bethesda, Md.
DATE SIGNED: 1-18-49

23. BURIAL, CREMATION REMOVAL (Specify): burial
DATE:
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG. 1-18-49

REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR: J. D. P. ADDRESS: W. W. CHAMBERS, 517 11th St., S.E., Wash., D.C.

RECEIVED
JAN 20 1949
BUREAU V. S.

EVIDENCE FOR BIRTH DATE + AGE IS ON:

FILM No. G 119 APR 13 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

442 0659

CERTIFICATE OF DEATH

131a Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brinklow, Md
LENGTH OF STAY (in this place) all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brinklow
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Louisa (Last) Matthews

4. DATE OF DEATH (Month) Jan. (Day) 12 (Year) 1949

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH Nov. 11, 1878 ABT. 1874
9. AGE last birthday N 75 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Talbert Pratt
14. MOTHER'S MAIDEN NAME Isabelle Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Beatrice Lee (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: Jan 2 49

Antecedent cause(s) (b) Heart Block — May 3, 46

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive Cardiorenal Disease — Chronic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Nov 24 48
19b. MAJOR FINDINGS OF OPERATION Nov 24 48 abscess under Bunion
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 3, 1934, to Jan 12, 1949, that I last saw the deceased alive on Jan 12, 1949, and that death occurred at 11:30 P m., from the causes and on the date stated above.

SIGNATURE Webster Sewell, M.D. (Degree or title) ADDRESS Norbeck DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE Jan. 16, 1949 NAME OF CEMETERY OR CREMATORY Sandy Spring LOCATION (City, town, or county) Sandy Spring, Md (State)

DATE REC'D BY LOCAL REG. 1-16-49 REGISTRAR'S SIGNATURE Gertrude B Lawler
24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

322.0
77e

0660

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montg Co.

City or town: Hyattstown. Md,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6Yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Mont.

City or town: HYATTSTOWN
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Johnson McBain

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 6th 1913

8. AGE: Years 35 | Months 5 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace: Clarksburg Md,
(Town, county, and state)

10. Usual occupation: House Keeping

11. Industry or business

FATHER
12. Name: Willie J Johnson
13. Birthplace: Clarksburg, Md,

MOTHER
14. Maiden name: Lula V. Carter
15. Birthplace: Clarksburg Md,

16. Informant: Willie J Johnson
Address: Clarksburg, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/49 (month) (day) (year)

Cemetery or crematory: Clarksburg Cemetery
Location: Clarksburg, Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Jan. 3 1949 (Date rec'd by registrar) Abade G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2 1949 at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1948 to Jan 2 1949
and that I last saw h alive on 1949

Immediate cause of death	DURATION
Cerebral edema	Few hrs
Due to: Acute alcoholism	Few days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Burkhart M.D.
M. D. or other

Address: Gaithersburg Md Date signed 1-2-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

0661

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

94a Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5909 Beach Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 5909 Beach Ave

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Leslie (Last) McCuen

4. DATE OF DEATH (Month) Jan (Day) 21 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 2/13/1891
9. AGE last birthday 57 yrs. If under 1 year Months 11 Days 8 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Mgr.
10b. KIND OF BUSINESS OR INDUSTRY Hotel Supply
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Wm. H. McCuen
14. MOTHER'S MAIDEN NAME Effie Cooke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. # Unknown
17. INFORMANT Grace McCuen (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: died suddenly

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep. Med. Exam. case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8:10 P m., from the causes and on the date stated above.

SIGNATURE Frank J Broschart M.D. Dep. Med. Exam. (Degree or title) ADDRESS Gaithersburg Md DATE SIGNED 1-21-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/24/1949
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) (State) Suitland, Maryland

DATE REC'D BY LOCAL REG. 1-24-49
REGISTRAR'S SIGNATURE W. E. Jobes
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4500

0662

CERTIFICATE OF DEATH 131

Reg. Dist. No. 2-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Olney
LENGTH OF STAY (in this place): 5 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: The Montgomery County General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel
STREET ADDRESS (If rural, give location): R. F. D.

3. NAME OF DECEASED (Type or Print): (First) Bertha (Middle) B. (Last) Milstead

4. DATE OF DEATH: (Month) January (Day) 12 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Aug. 27 1878

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Rockville, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward H. Briggs

14. MOTHER'S MAIDEN NAME: Frances P. Beckwith.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uraemia	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Interstitial Nephritis	1 yr
	(c) Senile Arteriosclerosis	2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): — (COUNTY): — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan., 19 47, to Jan. 12, 19 49, that I last saw the deceased alive on Jan. 12, 1949, and that death occurred at 8 06 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [illegible] M.D. ADDRESS: Sandy Spring, Maryland. DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): DATE: Jan. 15, 1949 — NAME OF CEMETERY OR CREMATORY: Burtonsville Union Cem. — LOCATION (City, town, or county) (State): Burtonsville, Md.

DATE REC'D BY LOCAL REG.: Jan 12-49 — REGISTRAR'S SIGNATURE: Gertrude B Fowler

24. FUNERAL DIRECTOR: Wm R. Pumphrey Funeral Home — ADDRESS: Beth. Md.

RECEIVED
FEB 3 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF BIRTH DATE SHOWN ON:

0663

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443

FILM No. G 118 JAN 24 1949

CERTIFICATE OF DEATH

61 Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (in this place) 3 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium + Hosp.	STREET ADDRESS (If rural, give location) Shady Grove Rd.

3. NAME OF DECEASED (Type or Print)	(First) SARAH	(Middle) JANE	(Last) MITCHELL	4. DATE OF DEATH	(Month) Jan.	(Day) 13	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 3-7-78	9. AGE last birthday 70 ~~69~~ yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Duffy		14. MOTHER'S MAIDEN NAME Catherine Cunningham.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Record - Wash. San + Hosp.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pneumonia - Bronchial	Terminal
Antecedent cause(s)	(b) Congestive Cardiac Failure	Four days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) [Secondary Anemia] Hypertension	? Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Secondary Anemia, Diabetes Mellitus	?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from January 10, 1949, to January 13, 1949, that I last saw the deceased alive on Jan. 13, 1949, and that death occurred at 6:35 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert A Hare MD		Takoma Park, Md.	1/13/49

23. BURIAL, CREMATION REMOVAL (Specify) Shipment	DATE Jan. 13, 1949	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) West Orange, N.J.	(State)
DATE REC'D BY LOCAL REG. 1/13/49	REGISTRAR'S SIGNATURE J. W. Dandley Deputy	24. FUNERAL DIRECTOR The C. H. Hines Co. 2901 14th St NW.		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0664

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 16 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2472 Phillips St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: MOLTON, William Eugene

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	married

6.(b) Name of husband or wife: Mary Molton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 13, 1890

8. AGE: Years	Months	Days	If less than one day
58	11	24	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: MOLTON, John dec.
13. Birthplace: Md.

MOTHER
14. Maiden name: BOOSE, Mary dec.
15. Birthplace: Va.

16. Informant: Wife: Mrs. Mary Molton

Address: 2472 Phillips St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-12-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. ERNEST JARVIS M.E.D.

Address: 1432 U St., N.W.

19. 1-7- (Date rec'd by registrar) 19 49 Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 January 19 49 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 21 November 19 48 to 7 January 19 49 and that I last saw h im alive on 7 January 19 49

Immediate cause of death	DURATION
a Meningitis Cerebro-spinal, Tuberculous	1 month
Due to: Tuberculosis	
Due to:	
Other conditions: Extensive pulmonary fibrosis and cavitation (Include pregnancy within 3 months of death)	1 yr?

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John W. Flynn
J. W. FLYNN, Lt JC MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 1-7-49

RECEIVED
JAN 11 1949
BUREAU V. S.

0665

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 2 mons. 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D. C. COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): 2406 Pennsylvania Avenue, N.W.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Andrew	Jackson	MORGAN	January	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	2-18-15	33 yrs.	11	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mail Clerk	Government	New Jersey	US

13. FATHER'S NAME: MORGAN, Joseph P.

14. MOTHER'S MAIDEN NAME: WALTON, Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWII		wife: Mrs. Anna A. Morgan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchogenic Carcinoma Right Lung.	5 Months
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 13 Nov, 1948, to 19 Jan, 1949, that I last saw the deceased alive on 19 Jan, 1949, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. T. Jones, Jr., Lt. JG MC USN, US Naval Hospital, Bethesda, Md. 1-19-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
burial	1-26-49	Arlington National	Arlington	Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-19-49	Mary E. Patterson	W. W. CHAMBERS, Georgetown, D.C.	

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0666

082 81a

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1223 Fairmont St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: MOTEN, Harry Livingston

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 11, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	4	22		

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER — 12. Name: MOTEN, Thomas dec

13. Birthplace: Va.

MOTHER — 14. Maiden name: SCOTT, Roberta, dec

15. Birthplace: Wash., D.C.

16. Informant: sister: Miss Geraldine Moten

Address: 1223 Fairmont St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-7-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U St., N.W., Wash., D.C.

19. 1-4- 19 49 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 January 19 49, at 1:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 December 19 48, to 3 January 19 49

and that I last saw him alive on 3 January 19 49

Immediate cause of death	DURATION
meningo-encephalitis	5 Days?
Due to	
Due to	
Other conditions: Pulmonary edema	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. P. Hightower D. P. HIGHTOWER, Cdr. MC USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 1-4-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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JAN 7 1949
BUREAU T. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 932 0667

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clagettsville, Rural — LENGTH OF STAY (in this place): 77 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: None

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clagettsville, MD.
STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): (First) Basil (Middle) E. (Last) Moxley

4. DATE OF DEATH: (Month) Jan (Day) 31 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 25. 1871

9. AGE last birthday: 77 yrs. If under 1 year: Months 4, Days 6, Hours, Min. If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Moxley

14. MOTHER'S MAIDEN NAME: Margaret Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: Mrs. Grover Butcher

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bilateral bronchopneumonia — Interval Between Onset and Death: 1 week.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Arteriosclerotic cardiovascular disease. — 15 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 8 1946 to January 31, 1949, that I last saw the deceased alive on January 28, 1949, and that death occurred at 4:00 P. m., from the causes and on the date stated above.

SIGNATURE: James P. Kerr M.D. (Degree or title) ADDRESS: Damascus, Md. DATE SIGNED: February 2, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Feb. 3 1949 — NAME OF CEMETERY OR CREMATORY: Montgomery — LOCATION (City, town, or county) (State): Clagettsville, MD.

DATE REC'D BY LOCAL REG. Feb. 3 1949 — REGISTRAR'S SIGNATURE: Della N. Burdette

24. FUNERAL DIRECTOR: Roy W. Barber — ADDRESS: Laytonsville, MD.

RECEIVED
FEB 4 1949
BUREAU V. S.

0668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

241
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Archie (Middle) L. (Last) Neal

4. DATE OF DEATH (Month) Jan. (Day) 28, (Year) 1949

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH April 30 1898 | 9. AGE last birthday 50 yrs. yrs. | If under 1 year Months. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Neal | 14. MOTHER'S MAIDEN NAME Arealia McAbee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. 578-26-4559 | 17. INFORMANT Sarah E. Taylor (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Bronchial asthma.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) No | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | (CITY OR TOWN) Gaithersburg, (COUNTY) Montgomery (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan 28, 1949, to Jan 28, 1949, that I last saw the deceased alive on Jan 28, 1949, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE P. Mary Shirley (Degree or title) Md | ADDRESS Gaithersburg | DATE SIGNED Md Jan. 30/49

23. BURIAL, CREMATION REMOVAL (Specify) | DATE Jan. 31, 1949 | NAME OF CEMETERY OR CREMATORY Emory Grove | LOCATION (City, town, or county) Gaithersburg, Md (State)

DATE REC'D BY LOCAL REG. Jan 30, 1949 | REGISTRAR'S SIGNATURE Alneda L. Cooke | 24. FUNERAL DIRECTOR Robert L. Snowden | ADDRESS Rockville, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1
93d

0669

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5342 Ames St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME
NEWBERRY, Harry Frederick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Pearl B. Newberry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 15, 1889

8. AGE:

Years	Months	Days	If less than one day
59	9	20	..... hrs. ..... min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: US Government

FATHER
12. Name: NEWBERRY, Lloyd
13. Birthplace: N.Y.

MOTHER
14. Maiden name: COLEMAN, Elizabeth
15. Birthplace: N.Y.

16. Informant: wife: Mrs. Pearl B. Newberry
Address: 5342 Ames St., N.E., Wash., D.C.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 1-12-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Barbour Funeral Home R.B.
Address: 48 K St., N.E., Wash., D.C.

19. 1-6- 1949
(Date rec'd by registrar)
Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 January 1949 at 11:30PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 December 1948 to 5 January 1949 and that I last saw him alive on 5 January 1949

Immediate cause of death	DURATION
1 Thrombosis Coronary Artery	?
Due to: Hypertensive heart Disease	6 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Queen
Wm. F. QUEEN, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-6-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1 94a

0670

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:
U S Naval Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8445 Piney Branch Road
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. 1 Army

3. (a) FULL NAME: NEWCOMB, Ralph Leroy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ____ (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 12-14-1891

8. AGE: Years	Months	Days	If less than one day
57	0	18	____ hrs. ____ min.

8. Birthplace: Massachussets
(Town, county, and state)

10. Usual occupation: Expiditer

11. Industry or business

FATHER — 12. Name: Louis F. Newcomb

13. Birthplace: Maine deceased

MOTHER — 14. Maiden name: Florence N. Fergenson

15. Birthplace: Canada living

16. Informant: Brother: Basil Newcomb

Address: 8445 Piney Branch Road Silver Spring, Md

17. Burial (Burial, cremation, or removal. Which?) Removal Date thereof: Jan. 3, 1949 (month) (day) (year)

Cemetery or crematory: Vernon Grove Cemetery

Location: Milford Mass

18. Funeral director: W.W. Chambers

Address: 1400 Chapin St NW Wash. D.C.

19. 1-2-49 (Date rec'd by registrar)

Mary C. Patterson Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 January 1949 at 1220A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 December 1948 to 2 January 1949 and that I last saw him alive on 2 January 1949

Immediate cause of death	DURATION
Perforation, Interventricular Septum	
Due to: Thrombosis, Coronary Artery	4 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W.F. QUEEN CDR MC USN
M. D. or other

Address: U S NAVAL HOSPITAL Bethesda, Maryland Date signed: 1-2-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Any correction is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

RECEIVED
JAN 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97 447X 0671

CERTIFICATE OF DEATH

Reg. Diat. No. 216

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 103 Newland St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 Newland St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jesse W. Nicholson

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mollie E. Davis Nicholson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 1 1870
8. AGE: Years 77 Months 8 Days 1 If less than one day ..... hrs. ..... min.
9. Birthplace: Monty. Co. Md (Town, county, and state)
10. Usual occupation: Attorney - retired
11. Industry or business
FATHER 12. Name: John Thomas Nicholson
13. Birthplace: Monty. Co. Md
MOTHER 14. Maiden name: Mary Elizabeth Pickens
15. Birthplace: Monty Co. Md.
16. Informant: Mrs Mollie E. Nicholson
Address 103 Newland St. Chevy Chase, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1949 (month) (day) (year)
Cemetery or crematory Rock Creek
Location Washington D.C.
18. Funeral director Warner E. Pumphrey, Inc.
Address 8434 Ga. Ave. Silver Spring Md.
19. 1-4 1948 W.E. Jones. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1949 at 11:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to Jan. 2 1949 and that I last saw him alive on Jan. 1 1949
Immediate cause of death

	DURATION
Pulmonary em-	15 minutes
Due to Embolism	
Due to Arteriosclerosis and hypertension.	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wheeler O. Huff - M.D. M. D. or other
Address Bethesda, Md. Date signed Jan. 4 49

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JAN 7 1949
BUREAU V. S.

mr

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0672

8255

CERTIFICATE OF DEATH

170 C

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Monty MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville (rural) LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) 803 Grandview Ave

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Henry (Last) Norwood

4. DATE OF DEATH (Month) Jan (Day) 29 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Widowed	Sept 21 1904	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Laborer	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bradly J. Norwood	Margent Trail

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		220-26-6780	Hosp records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Fracture of skull (accidental)	Killed instantly
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
accident	highway	Rockville	Monty	Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☑	HOW DID INJURY OCCUR?
1 - 29 - 49 - 6:30 P m.		Auto accident

22. I hereby certify that I attended the deceased from Def Med Exam case, that I last saw the deceased alive on ....., 19....., and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Broschach M.D.	Def Med Exam	Gaithersburg Md	1-29-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/1/49	Monocacy Cemetery	Beallsville	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 31/49	Alfreda G. Cooke	E. C. Gartner	Gaithersburg Md

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

442 131a

0673

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda — LENGTH OF STAY (in this place): 15 Mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5510 Moorland Lane	STREET ADDRESS (If rural give location): 5510 Mooreland Lane

3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) ARTHUR	(Last) PARKER	4. DATE OF DEATH	(Month) 1 - (Day) 19 (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Sept 23/62	9. AGE last birthday: 86 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired	10b. KIND OF BUSINESS OR INDUSTRY: Not known	11. BIRTHPLACE (State or foreign country): Boston, Mass.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Orin Parker	14. MOTHER'S MAIDEN NAME: Julia Ann Fuller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Clement A. Parker			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Heart Failure — 4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-vascular-renal disease — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute Upper Respiratory Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1949, to Jan 19, 1949, that I last saw the deceased alive on Jan 18, 1949, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Sidney C. Cousins, M.D. 3921 Ingomar St. N.W. Wash. D.C. 1-19-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Jan. 21/49	NAME OF CEMETERY OR CREMATORY: Springhill Cemetery	LOCATION (City, town, or county) (State): Easton, Md.
DATE REC'D BY LOCAL REG.: 1-20-49	REGISTRAR'S SIGNATURE: N. E. Jobes	24. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0822 0674

107 Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1704 N. Uhle St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WWII ✓

3.(a) FULL NAME: PATTON, Horace Milton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Avis Patton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16, 1890

8. AGE: Years	Months	Days	If less than one day
58	5	24	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Engineer, Federal Power Comm.

11. Industry or business: US Government

FATHER
12. Name: PATTON, Thomas F. dec.
13. Birthplace: Pa.

MOTHER
14. Maiden name: GILL, Maria, dec.
15. Birthplace: Pa.

16. Informant: wife: Mrs. Avis Patton
Address: 1704 N. Uhle St., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-13-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers

Address: Georgetown, D.C.

19. 1-10 19 49 Mary C. Patterson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 January 19 49 at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 19 49 to 10 January 19 49 and that I last saw h... im alive on 10 January 19 49

Immediate cause of death	DURATION
Bronchopneumonia	7 days
Due to: Paralysis agitans	
post encephalitic	6 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. T. JONES, Jr., Lt JG MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-10-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 13 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

180
520

0675

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH · COUNTY: Montgomery · MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Missouri · COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural) · LENGTH OF STAY (in this place): 3 mons. 5 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sedalia
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital	STREET ADDRESS (If rural give location): 210 E. Morgan Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Mouth)	(Day)	(Year)
Robert	Frank	Phillips	January	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	Colored	single	9-23-86	62 yrs.	3	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknown	unknown	Missouri	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PHILLIPS, Silas Frank	BUTLER, Sadie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WW I		father: Mr. Silas F. Phillips

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypernephroma, bilat. c metastases	long time
Antecedent cause(s)	To lymph nodes & lungs	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct. 15, 1948, to Jan. 20, 1949, that I last saw the deceased alive on Jan. 20, 1949, and that death occurred at 9:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Wm. W. Miller Jr., Lt. MC USN	USNaval Hospital, Bethesda, Md.	1-20-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Transportation	1-22-49		Sedalia, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-20-49	Mary C. Patterson	W.E. Jervis	1432 U.St.N.W., Wash, D.C.

RECEIVED
JAN 25 1949
BUREAU V. S.

0676

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170/50

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Colesville, Md. - R.F.D. #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Colesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #2 Silver Spring, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lorna L. Pickens — Lorna L. Pickens

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wh.	Married

6.(b) Name of husband or wife Hayward F. Pickens

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1914

8. AGE:

Years	Months	Days	If less than one day
34	10	29	..... hrs. ..... min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Harvie W. Snyder
13. Birthplace West Virginia

MOTHER
14. Maiden name Eliza F. Stultz
15. Birthplace West Virginia

16. Informant Hayward F. Pickens (husband)
Address R.F.D. # 2 - Silver Spring, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan. 4, 1949 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Prince Geo. County, Md

18. Funeral director Warner E. Pamphrey, Inc

Address Silver Spring, Md.

19. Jan 3 1949 Josephine Schoeffle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1949 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1949 to Jan 1, 1949 and that I last saw her alive on Jan 1 1949

	DURATION
Immediate cause of death Cerebral metastases & hemorrhage	6 wks. 1 day
Due to Carcinoma of breast	6 yrs.
Due to	
Other conditions Metastases to lungs	2 yrs.
" " spine	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Rogers M.D. M. D. or other

Address 9601 Sutton Pl. Silver Spring Md. Date signed Jan 2 49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0677 154 H60 Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) | LENGTH OF STAY (in this place) 33 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 1527 Rhode Island Avenue, N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) Leo (Last) POLLETT

4. DATE OF DEATH: (Month) January (Day) 28 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 3-24-90

9. AGE last birthday: 58 yrs. If under 1 year: Months 10 Days 4 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civilian Guard

10b. KIND OF BUSINESS OR INDUSTRY: US Government

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert Pollett

14. MOTHER'S MAIDEN NAME: Florence Tinsley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yse (If year, give war or dates of service): WWI

16. SOCIAL SECURITY NO.

17. INFORMANT: brother: Mr. Irvin Pollett, Route #2 Cameron, Mo.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma, Rectum — Interval between onset and death: 5 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED Whila nt Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 Dec., 1948, to 28 Jan., 1949, that I last saw the deceased alive on 28 Jan., 1949, and that death occurred at 1:35 A m., from the causes and on the date stated above.

SIGNATURE Wm. A. Dinsmore (Degree or title) ADDRESS Wm. A. DINSMORE, Lt. Comdr. MC USN, US Naval Hospital, Bethesda, Md. DATE SIGNED 1-28-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE | NAME OF CEMETERY OR CREMATORY: Stanford Cemetery | LOCATION (City, town, or county) (State): Stanford, Nebraska

DATE REC'D BY LOCAL REG. 1-28-49 | REGISTRAR'S SIGNATURE: Mary E. Patterson

24. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: W. W. CHAMBERS, Georgetown, D.C.

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0678

334/97

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY

City or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 YRS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)

Street No. #6 QUINCY STREET
(If rural, give LOCATION)

2.(a) If veteran, name war NO

3. (a) FULL NAME J. ERIS POWELL

3. (b) Social Security Number 213-14-5224 A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARY C. POWELL

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) JAN. 21, 1877

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace TENN
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business REAL ESTATE

FATHER
12. Name AUSTIN POWELL
13. Birthplace KY.

MOTHER
14. Maiden name EMILY THOMPSON
15. Birthplace NORTH CAROLINA

16. Informant JOHN E. POWELL

Address 18 HESKETH ST CH. CH. MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Jan 10, 1949 (month) (day) (year)

Cemetery or crematory ~~Mt Olivet~~ St. Mary's

Location Washington D.C.

18. Funeral director Francis J. Collins

Address 3821-14th St. N.W. Wash. D.C.

19. 1-8-49 19 (Date rec'd by registrar) W.E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1949, at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1948, to 1/8 1949

and that I last saw him alive on 1/2/49 19

Immediate cause of death	DURATION
Anemia	10 mos
Due to Cerebral arteriosclerosis	3 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bernard J. Shally M.D. (M. D. or other)

Address 900-17th St. N.W. Washington D.C. Date signed 1/8/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 11 1949
BUREAU V. S.

215 – Kennedy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0679

422.1 936

Reg. Dist. No. 7-18

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Laytonsville, MD.
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: None

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Laytonsville, MD.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Cornelius (Middle) (Last) Prather

4. DATE OF DEATH: (Month) Jan. (Day) 26 (Year) 49

5. SEX: Male

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: July 15 1873

9. AGE last birthday: 75 yrs. If under 1 year: Months. 6 Days 11 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi Prather

14. MOTHER'S MAIDEN NAME: Martha Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Eugine Prather

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage — 4 days.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic cardiovascular disease. — 15 years.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1948, to January 26 1949, that I last saw the deceased alive on January 24, 1949, and that death occurred at 1:00 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James D. Kerr M.D. Damascus Md. 1/27/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Jan 28.1949

NAME OF CEMETERY OR CREMATORY: Brook Grove

LOCATION (City, town, or county) (State): Laytonsville, MD.

DATE REC'D BY LOCAL REG. 1/28/49

REGISTRAR'S SIGNATURE: R. D. Bell

24. FUNERAL DIRECTOR ADDRESS: Roy W. Barber Laytonsville, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157
46g

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:
US Naval Medical Center, Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1329 Holbrook St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: PRYOR, George Cameron

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

8.(b) Name of husband or wife: Margaret S. Pryor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 14, 1889

8. AGE: Years	Months	Days	If less than one day
59	10	19	..... hrs. ..... min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: Retired from Fed. Gov't.

FATHER
12. Name: PRYOR, George Crawford dec.
13. Birthplace: Ga.

MOTHER
14. Maiden name: HAYDEN, Elizabeth dec.
15. Birthplace: Ga.

16. Informant: wife: Mrs. Margaret S. Pryor
Address: 1329 Holbrook St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-10-49 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Lee Funeral Home J.E.O.
Address: 4th & Mass. Ave., N.E., Wash., D.C.

19. 1-4-49 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 January 1949 at 6:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 November 1948 to 3 January 1949 and that I last saw him alive on 3 January 1949

Immediate cause of death	DURATION
Biliary cirrhosis	26 mos.
Due to Cancer of head of pancreas	26 mos.
Liver Insufficiency.	
Due to Pulmonary edema	1 day
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. S. BOLES, Jr., Lt JG MCR USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-4-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE IS ON:

FILM No. G 118 FEB -2 1949

0681

443

932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Montgomery County

1. PLACE OF DEATH: COUNTY Bethesda Maryland — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Md. | LENGTH OF STAY (in this place) Since 1-15-49
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural give location) 65 Decatur St.

3. NAME OF DECEASED (Type or Print): (First) Lewis (Middle) N. (Last) Pugh

4. DATE OF DEATH: (Month) January (Day) 16 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, (WIDOWED) DIVORCED, (Specify)

8. DATE OF BIRTH: May 20 1868

9. AGE: Last birthday 80 77 yrs. | If under 1 year: Months Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S. of N. America

13. FATHER'S NAME: William Pugh

14. MOTHER'S MAIDEN NAME: Mary Louisa Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Not | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Vincent E. Pugh - son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive - Arteriosclerotic Cardio -

(c) Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/15, 1949, to 1/16, 1949, that I last saw the deceased alive on 1/16, 1949, and that death occurred at 3:40 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

James E Boyland, M.D. | Suburban Hospital | 1/16/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE JAN. 19, 1949 | NAME OF CEMETERY OR CREMATORY Bethesda Presbyterian Cemetery | LOCATION (City, town, or county) (State) Bethesda, Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE W. E. Forbes | 24. FUNERAL DIRECTOR ADDRESS Robert A. Dumphreys - Rockville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0682

444
107

Reg. Dist. No. 216

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (In this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda,
STREET ADDRESS (If rural, give location): 4916 Hampden Lane

3. NAME OF DECEASED (Type or Print): (First) Nannie (Middle) Eugenia (Last) Ramer

4. DATE OF DEATH: (Month) 1/9/49 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 11/2/1859

9. AGE last birthday: 89 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): W.Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: G.A.Chrisman

14. MOTHER'S MAIDEN NAME: Nancy Lingamfelter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Wm. A. Ramer -Bethesda, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Broncho pneumonia	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypostatic pneumonia	4 years
	(c) Fractured hip (Bed rest)	14 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr, 19[illegible], to Jan 9, 19[illegible], that I last saw the deceased alive on Jan 9, 19[illegible], and that death occurred at 9:45 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Bruce F. Benjamin M.D. Bethesda, Md. 1/10/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 1/12/49

NAME OF CEMETERY OR CREMATORY: Greenhill Cemetery

LOCATION (City, town, or county) (State): Martinsburg, W.Va.

DATE REC'D BY LOCAL REG.: 1-11-49

REGISTRAR'S SIGNATURE: W. E. Johns

24. FUNERAL DIRECTOR ADDRESS: Wm. Reuben Pumphrey Funeral Home

Wm Reuben Pumphrey Funeral Home.

VS. A15

RECEIVED
JAN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

443
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Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 hrs

Hospital, institution, or street address where death occurred:
Washington Sanitarium - Tk. Pk. Md.

How long in hospital or institution? 15 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State District of Columbia County —

City ~~or town~~ Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3103 South Dakota Ave. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Henry Julius Rassier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 15 1873

8. AGE:

Years	Months	Days	If less than one day
75	5	20	— hrs. - min.

9. Birthplace Shenandoah Penna.
(Town, county, and state)

10. Usual occupation Retired Government Worker

11. Industry or business

FATHER
12. Name John Rassier
13. Birthplace Alsace - Lorraine - France

MOTHER
14. Maiden name Caroline Duble
15. Birthplace Germany

16. Informant Wash. San. Records.
Address Takoma Park. Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan. 6, 1949 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cem

Location Prince George County

18. Funeral director S H Hines Co
Address 2901-14th N.W.

19. Jan - 5 - 1949 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 5, 1949 at 5:18 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 3, 1949 to Jan - 5, 1949 and that I last saw him alive on Jan - 5, 1949

	DURATION
Immediate cause of death Hypertensive Cardio-vascular disease	unknown
Due to Hypertension of lesser circulation	unknown
Due to	
Other conditions Intestinal obstruction, partial, due to undetermined cause	3 days

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edwin P. Hall, M.D. M.D. or other

Address 1411 Forest Glen Road Silver Spring, Md. Date signed Jan. 5, 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0684

420.0

932

CERTIFICATE OF DEATH

Reg. Dist. No. 414

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 12 days

Hospital, institution, or street address where death occurred:

Jolliffe Nursing Home

How long in hospital or institution? 1 year 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6335-3Pst Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Kate S. Reed

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James S. Reed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1860

8. AGE: Years 88 | Months 6 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Dennis Byone

13. Birthplace Ireland

MOTHER 14. Maiden name Mary P. Abs

15. Birthplace Ireland

16. Informant Mrs. Margaret Merritt

Address 7729-16th Street N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1949 (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery

Location Washington D.C.

18. Funeral director The S. E. Hines Co.

Address 2901-14th Street N.W. Washington, D.C.

19. Jan. 16 1949 Josephine M. Schaffe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1949 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-4 1948, to 1-16 1949 and that I last saw h.e.r alive on 1-12- 1949

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Arteriosclerotic Heart Disease with Heart Block	
Due to Generalized Arteriosclerosis	
Other conditions Arteriosclerotic Gangrene Left Foot	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dean K. Harding M.D. M. D. or other

Address 113 Carroll St NW Wash DC Date signed 1-16-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

CO 7023

RECEIVED
JAN 18 1949
BUREAU V. S.

0685

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170 C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Md. — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Springs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital	STREET ADDRESS (If rural give location): 1611 Dennis Avenue

3. NAME OF DECEASED (Type or Print)	(First) Josie	(Middle) V	(Last) Rider	4. DATE OF DEATH	(Month) 1 (Day) 23 (Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: 9-8-1889	9. AGE last birthday: 59 yrs.	If under 1 year: Months 4, Days 15; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cosmetic Representative	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Kansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME: James E. Dunkerley		14. MOTHER'S MAIDEN NAME: Mary Frances Northan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: 579-40-5000	17. INFORMANT: Chester A. Jones			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage due to	1 hr. - 15 min
Antecedent cause(s)	(b) fracture of skull (accidental)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway	(CITY OR TOWN): Silver Spring	(COUNTY): Marty.	(STATE): md
TIME OF INJURY (Month) (Day) (Year) (Hour): 1 - 23 - 49 9:30 A.m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR? auto accident		

22. I hereby certify that I attended the deceased from Def. Med. Exam. Case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 10:45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Broschart M.D. Def. Med. Exam.		Gaithersburg Md	

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Jan. 29, 1949	NAME OF CEMETERY OR CREMATORY: Forest Hill Cemetery	LOCATION (City, town, or county) (State): Kansas City, Missouri
DATE REC'D BY LOCAL REG.: 1/28/49	REGISTRAR'S SIGNATURE: W. E. Jobes	24. FUNERAL DIRECTOR: Warner E. Pumphrey	ADDRESS: Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 29 1949
BUREAU T. S.

Ridgway 0686

420.1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

94a Reg. Dist. No. 216

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase — LENGTH OF STAY (in this place) 17	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6313 Broadbranch Rd.	STREET ADDRESS (If rural, give location) 6313 Broadbranch Road

3. NAME OF DECEASED (Type or Print) (First) Roscoe (Middle) Alan (Last) Ridgway			4. DATE OF DEATH (Month) Jan. (Day) 27 (Year) 49 19		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 23, '88	9. AGE last birthday 60 yrs.	If under 1 year Months. Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Pharmacy	11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME E.A.Ridgway			14. MOTHER'S MAIDEN NAME Isabell Heiberger		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) W.W.I		16. SOCIAL SECURITY NO. 579-22-2252	17. INFORMANT Mrs. Gertrude Ridgway (wife)		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Infarction — 20 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Thrombosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 Jan., 1949, to 27 Jan., 1949, that I last saw the deceased ~~alive on~~ ....., 19....., and that death occurred at 1:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Pt. was dead on my arrival S. Richard Bousefield MD 7345 Wisconsin Ave 1/27/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1-31-49	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Va.
DATE REC'D BY LOCAL REG. 1-30-49	REGISTRAR'S SIGNATURE N.E. Jobes	24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS Bethesda Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 0687

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place) 6 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laytonsville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) H. (Last) Riggs.

4. DATE OF DEATH: (Month) January (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married.

8. DATE OF BIRTH: March 5, 1870

9. AGE last birthday: 78 yrs. If under 1 year: Months: Days: If under 24 hrs.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Unity, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elisha Riggs

14. MOTHER'S MAIDEN NAME: Margaret Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage.	2 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-vascular disease	3 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN): — (COUNTY): — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Jan. 15, 1949, that I last saw the deceased alive on Jan. 15, 1949, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Sandy Spring, Maryland. DATE SIGNED 1/17/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 1/18/49 | NAME OF CEMETERY OR CREMATORY Laytonsville | LOCATION (City, town, or county) (State) Laytonsville, Md.

DATE REC'D BY LOCAL REG. 1/17/49 | REGISTRAR'S SIGNATURE Gertrude B. Lawler | 24. FUNERAL DIRECTOR AND ADDRESS Roy W. Barber, Laytonsville Md.

RECEIVED
FEB 3 1949
BUREAU V. S.

EVIDENCE FOR ADDITION + CORRECTIONS OF ITEMS #3, 8, 9 + 11 IS ON:
FILM No. G 118 FEB -2 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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0688

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 7-8 yrs ?
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE 6208 Wisconsin Ave COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase Md.
STREET ADDRESS (If rural give location) 6208 Wisconsin Ave

3. NAME OF DECEASED (Type or Print) (First) (ANNA) Ann (Middle) McCray (Last) Rinaldo

4. DATE OF DEATH (Month) Jan (Day) 24 (Year) 1949

5. SEX F
6. COLOR OR RACE Wh
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH April 30, ~~1912~~ 1909
9. AGE last birthday ~~36~~ 39 yrs. If under 1 year Months 8 Days 24 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier
10b. KIND OF BUSINESS OR INDUSTRY Hospital
11. BIRTHPLACE (State or foreign country) ~~Buchannon~~ BROXTON, W. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S. of N. America

13. FATHER'S NAME Vance McCray
14. MOTHER'S MAIDEN NAME Cora Vrahard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 234-14-8988
17. INFORMANT Application form (Her own writing

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Nicotine poisoning (Black Leaf) and — INTERVAL BETWEEN ONSET AND DEATH 1 hr. +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) D.D.T. Poisoning 95% in Xylol

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) suicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Bethesda (COUNTY) Montg (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dep. Med. Exam. Case 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE Frank J. Broschart (Degree or title) Dep. Med. Exam. ADDRESS Gaithersburg DATE SIGNED Md

23. BURIAL, CREMATION REMOVAL (Specify) DATE 1/25/49 NAME OF CEMETERY OR CREMATORY Removal to Balto, Md. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 1/25/49 REGISTRAR'S SIGNATURE W. E. Jobes
24. FUNERAL DIRECTOR The D.H. Hines Co. ADDRESS 2901-14th St NW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

151 M689

Reg. Dist. No. 215

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 1426 44th St., N. E.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Burke (Last) Robertson Jr.

4. DATE OF DEATH (Month) January (Day) 27 (Year) 1949

5. SEX male

6. COLOR OR RACE Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH 11-15-16

9. AGE last birthday 32 yrs. If under 1 year Months 2 Days 22 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger

10b. KIND OF BUSINESS OR INDUSTRY US Government

11. BIRTHPLACE (State or foreign country) La.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME ROBERTSON, William Burke, Sr.

14. MOTHER'S MAIDEN NAME REAUX, Lora

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWII

16. SOCIAL SECURITY NO.

17. INFORMANT wife: Mrs. Eddy M. Robertson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Intestional Obstruction	7 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) gastric Carcinoma	6-7 mos
	(c)	

151 46.2

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Summer of 48

19b. MAJOR FINDINGS OF OPERATION Gastric Carcinoma

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 Jan., 1949, to 27 Jan., 1949, that I last saw the deceased alive on 27 Jan., 1949, and that death occurred at 11:55 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. M. HANNER, Cdr. MC USN US Naval Hospital, Bethesda, Md. 1-27-49

23. BURIAL, CREMATION REMOVAL (Specify) burial

DATE THEREOF 2-1-49

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) (State) Arlington, Va.

DATE REC'D BY LOCAL REG. 1-27-49

REGISTRAR'S SIGNATURE Mary V. Patterson

24. FUNERAL DIRECTOR ADDRESS W. Ernest Jarvis, 1432 U St., N.W., Wash., D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
FEB 1 1949
BUREAU V. S.

0690

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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94a

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garret Park — LENGTH OF STAY (in this place) 9 Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garrett Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS At Home	STREET ADDRESS (If rural give location) 4 Clearmont Place

3. NAME OF DECEASED (Type or Print)	(First) Jesse	(Middle) Shourds	(Last) Rogers	4. DATE OF DEATH	(Month) Jan	(Day) 13	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/14/95	9. AGE last birthday 53 yrs.	If under 1 year Months 1	Days 29	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Liberty, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph H. Rogers		14. MOTHER'S MAIDEN NAME Anna Shourds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Jesse S. Rogers (wife)	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — Found dead in bed

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dep. Med. Exam. Case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 1:00 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank J. Bronhart M.D. Dep. Med. Exam.		Gaithersburg	Maryland

23. BURIAL, CREMATION REMOVAL (Specify) Cremation	DATE 1/15/49	NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	LOCATION (City, town, or county) Washington, D.C.	(State)
DATE REC'D BY LOCAL REG. 1/14/49	REGISTRAR'S SIGNATURE W. E. Jobes	24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0691

490
108

Reg. Diat. No. 218

1. PLACE OF DEATH: Montg Co,
County
City or town Germantown Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County Montgomery
City or town GERMANTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sally Coleman Schaeffer

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Frank G, Schaeffer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6th 1860

8. AGE: Years 88 | Months 7 | Days ~~18~~ 16 | If less than one day ..... hrs. ..... min.

9. Birthplace: Fairfax Va,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

MOTHER FATHER
12. Name unknown
13. Birthplace
14. Maiden name unknown
15. Birthplace

16. Informant: Frank W. Schaeffer
Address: Garmantown, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/49 (month) (day) (year)
Cemetery or crematory Monacacy Cemetery
Location Beallsville Md,

18. Funeral director Ernest C Gartner
Address Gaithersburg Md,

19. Jan. 3 1949 (Date rec'd by registrar) Abuda G Cooke Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Jan 2nd 1949 at 10.20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-31- 1948 to Jan-2- 1949 and that I last saw her alive on Jan-2- 1949

	DURATION
Immediate cause of death	
Pneumonia	3 days
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Miller, M.D. M. D. or other
Address Gaithersburg, Md Date signed 1-3-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (In this place): 3 mons. 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D.C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location): 5950 Brooks Road, S.E. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Milton	Ferdinand	SCHMIDT	January	26	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	single	1-2-07	42 yrs.	0	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plaster		Washington, D.C.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SCHMIDT, Henry A.	SCHULTZ, Magdalene

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWII		mother: Mrs. Magdalene Schmidt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cirhosis, liver — 6 Months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7 Oct., 1948, to 26 Jan., 1949, that I last saw the deceased alive on 26 Jan., 1949, and that death occurred at 11:20 Pm., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. A. DINSMORE, Jr., LCdr. MC USN US Naval Hospital, Bethesda, Md. 1-27-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-31-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-27-49	Mary S. Patterson	Lee Funeral Home,	4th & Mass., Ave. N.E. Wash., D.C.

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RECEIVED
FEB 1 1949
BUREAU T. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH- COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Washington, D. C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 4 mons. 17 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location) 2216 Wyoming Avenue, N. W.

3. NAME OF DECEASED (Type or Print)	(First) David	(Middle) Foote	(Last) SELLERS	4. DATE OF DEATH	(Month) January (Day) 27 (Year) 1949
5. SEX male	6. COLOR OR RACE W-US	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 2-4-74	9. AGE last birthday 74 yrs.	If under 1 year Months 11 Days 23 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy	10b. KIND OF BUSINESS OR INDUSTRY Navy	11. BIRTHPLACE (State or foreign country) Texas	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME SELLERS, Edwin		14. MOTHER'S MAIDEN NAME FOOTE, Olive			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI & II	16. SOCIAL SECURITY NO.	17. INFORMANT wife: Mrs. Anita Sellers			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertensive heart disease

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral thromboses old & recent

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 10, 1948, to Jan. 27, 1949, that I last saw the deceased alive on 27 Jan., 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
P. L. Bates	P. L. BATES, Lt. JG MC USN,	US Naval Hospital, Bethesda, Md.	1-27-49

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 1-31-49	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) (State) Arlington, Va.
DATE REC'D BY LOCAL REG. 1-27-49	REGISTRAR'S SIGNATURE Mary C. Patterson	24. FUNERAL DIRECTOR Joseph Gawler, 1756 Pa.Ave., N.W., Wash., D.C	ADDRESS

JEH. #304

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 28 1949

EVIDENCE FOR INVERTING #18 b+c IS ON:

FILM No. G 11 MAR -7 1949

EVIDENCE FOR CHANGE OF AGE & BIRTH DATE IS ON:

FILM No. G 118 FEB 10 1949

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 46 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 1020 19th St. NW, Washington, D.C. ✓

3. NAME OF DECEASED (Type or Print): (First) David (Middle) John (Last) Shaw
4. DATE OF DEATH: (Month) January (Day) 29 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: ~~1-29-90~~ 1-1-90
9. AGE last birthday: 59 ~~58~~ yrs. If under 1 year: Months 8 Days 1 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): Utah
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Shaw
14. MOTHER'S MAIDEN NAME: Mary Rozina Cardon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): WWI
16. SOCIAL SECURITY NO.
17. INFORMANT: Marjorie Rae Hansen (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c) Diabetes mellitus,

(a) (b) Arteriosclerosis generalized

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 14, 1948, to Jan. 29, 1949, that I last saw the deceased alive on Jan. 29, 1949, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. F. Berry J. F. BERRY, LTJG, MC, USN U.S. Naval Hospital, Bethesda, Md. 1-30-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE | NAME OF CEMETERY OR CREMATORY: Ogden City Cemetery | LOCATION (City, town, or county): Ogden, (State): Utah

DATE REC'D BY LOCAL REG. 1-30-49 | REGISTRAR'S SIGNATURE: Mary E. Patterson

24. FUNERAL DIRECTOR: W. W. Chambers ADDRESS: 1400 Chapin St., N.W. Wash., D.C.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0695 2/6

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brookmont LENGTH OF STAY (in this place) 90 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 6447 Brooklane	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brookmont STREET ADDRESS (If rural give location) 6447 Brooklane

3. NAME OF DECEASED (Type or Print) (First) EDITH (Middle) ELIZABETH (Last) SHOEMAKER				4. DATE OF DEATH (Month) Jan. (Day) 21, (Year) 1949		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 8/31/1892	9. AGE last birthday 56 yrs.	If under 1 year Months 7 Days 10	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John Mossburg		14. MOTHER'S MAIDEN NAME Gertrude Stevens				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No	(If year, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr Leonard Shoemaker (Husband)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebal Apoplexy - Cardiac Failure	24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yrs
	(c) Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug. 1935 to Jan. 21, 1949 that I last saw the deceased alive on Jan. 21, 1949 and that death occurred at 6:40 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Francis V. Shoke M.D.	3323-Ost. N.W., D.C.	1/21/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/24/49	Potomac Church Cemetery	Potomac, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-23-49	V.E. Jobes	Robert A. Humphrey,	Bethesda, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.

0696

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

199.1
55

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 1 day - 22 hrs 40 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dickerson R.R. #2
STREET ADDRESS (If rural give location) R.R. #2

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) Lee (Last) Smith

4. DATE OF DEATH (Month) 1 (Day) 17 (Year) 49

5. ~~SEX~~ F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 3-23-1890

9. AGE last birthday 58 yrs. If under 1 year Months 1 Days 22 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph Redman

14. MOTHER'S MAIDEN NAME Octavia Redman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pelvic Carcinoma with Metastases

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/15, 1949, to 1-17, 1949, that I last saw the deceased alive on 1/17, 1949, and that death occurred at 6 40 A.m., from the causes and on the date stated above.

SIGNATURE James E Bogland, M.D. (Degree or title) ADDRESS Suburban Hospital DATE SIGNED 1/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1-21-49 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Prince Geo. Co. (State) Md.

DATE REC'D BY LOCAL REG. 1-17-49 REGISTRAR'S SIGNATURE W.E. Jobes.

24. FUNERAL DIRECTOR W.W. Chambers Co. ADDRESS 1400 Chapin St. N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

592 0697

CERTIFICATE OF DEATH 136 Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; LENGTH OF STAY (in this place) 5 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS East Middle Lane

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; STREET ADDRESS (If rural, give location) East Middle Lane

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) (Last) Smith

4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 13, 1888

9. AGE last birthday: 60 yrs. If under 1 year: Months 11, Days 10, Hours, Min. If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houseman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: Frank Smith

14. MOTHER'S MAIDEN NAME: Dora

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary E. Smith (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Nephritis (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Pulmonary tuberculosis [5/27/49 abs]

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7, 1949, to 1/24, 1949, that I last saw the deceased alive on 1/24, 1949, and that death occurred at ....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

C. L. Hawks. Rockville Md 1/24/49

23. BURIAL / CREMATION / REMOVAL (Specify) DATE: Jan. 27, 1949 NAME OF CEMETERY OR CREMATORY: Haiti LOCATION (City, town, or county) (State): Rockville, Maryland

DATE REC'D BY LOCAL REG. 1-27-49 REGISTRAR'S SIGNATURE: E P Thompson

24. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville, Md.

RECEIVED
JAN 28 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

0698

CERTIFICATE OF DEATH 131a

Reg. Dist. No. 213

1. PLACE OF DEATH
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
MARYLAND
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Montgo
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Ellen (Middle) Nora (Last) Snowden

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Nov. 4, 1875

9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George Wettles

14. MOTHER'S MAIDEN NAME: Isabella Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert L. Snowden (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio renal Disease	1936
	(c) Essential Hypertension	1936

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arthritis

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 17, 1936, to Jan 18, 1949, that I last saw the deceased alive on Jan 18, 1949, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Webb Sewell, M.D. Jan 20, 49.

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE: Jan 21, 49 | NAME OF CEMETERY OR CREMATORY: Emerson Park | LOCATION (City, town, or county) (State): Rockville, Md.

DATE REC'D BY LOCAL REG. 1/21/49 | REGISTRAR'S SIGNATURE: E P Thompson

24. FUNERAL DIRECTOR: R. L. Snowden & Davis ADDRESS: Rockville, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0699

331

830

Reg. Dist. No. 215

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Virginia — COUNTY: Prince William County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bristow
STREET ADDRESS (If rural, give location): RFD#1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Zeno	Hartwell	Spindle	January	31	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	10-6-77	71 yrs.	3	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Virginia	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Spotswood Spindle	Mary E. Patten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	Sp.Am.		759 Lang Place, N.E., Wash., D.C. Mrs Nellie M Mc Menamin (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemorrhage Cerebral	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis Generalized	Indefinite
	(c) Hypertension arterial	Indefinite

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan 27, 1949, to Jan 31, 1949, that I last saw the deceased alive on 31 Jan, 1949, and that death occurred at 11:35 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. F. Jones Jr	J. F. JONES, LTJG, MC, USN	U.S. Naval Hospital, Bethesda, Md.	1-31-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-3-49	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-31-49	Mary C. Patterson	W. W. CHAMBERS, 1400 Chapin St., N.W. Wash., D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 4 1949
BUREAU V. S.

0700

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 217

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Spencerville MD. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Spencerville LENGTH OF STAY (in this place) 81 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Spencerville, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS None	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) H.	(Last) Stabler	4. DATE OF DEATH	(Month) Jan	(Day) 24	(Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug 28.1867	9. AGE last birthday 81 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Sandy Spring MD.	12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME Henry C. Hallowell	14. MOTHER'S MAIDEN NAME Sarah Miller						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Stanley P. Stabler					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Infarct (Infarct)	1 hr
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Thrombosis left femoral artery	24
	(c) —	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1/23/, 1949, to 1/25/, 1949, that I last saw the deceased alive on 1/25/, 1949, and that death occurred at 1130 P m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Sandy Spring Md DATE SIGNED 1/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Jan. 26.1949	NAME OF CEMETERY OR CREMATORY Friends	LOCATION (City, town, or county) (State) Sandy Spring, MD.
DATE REC'D BY LOCAL REG. Jan 25-49	REGISTRAR'S SIGNATURE Gertrude B Lawler	24. FUNERAL DIRECTOR Roy W. Barber	ADDRESS Laytonsville, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0701

812.5 170C

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Aspen Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rockville Pike

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Margaret Josephine Stanton

3.(b) Social Security Number: 506-12-1548

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Anthony

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1883.

8. AGE:

Years	Months	Days	If less than one day
64	0	23	hrs. min.

9. Birthplace: Battle Creek Neb. (town, county, and state)

10. Usual occupation: Clerk - Dept. of Agriculture

11. Industry or business

FATHER 12. Name: George Connelly

13. Birthplace: Ireland

MOTHER 14. Maiden name: Sarah Flood

15. Birthplace

16. Informant: Margaret Mary Calderone

Address: 7245 Arlington Ave -

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1949 (month) (day) (year)

Cemetery or crematory: St. Marys

Location: Rockville, Md.

18. Funeral director: Wm. Reuben Pumphrey Funeral Home.

Address: Bethesda, Maryland

19. 1-6 1949 (Date rec'd by registrar) W E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4, 1949, at 7 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 Case 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of cervical Vertebrae	Killed instantly
Due to (accidental)	
Due to	
Other conditions: Fracture of both legs	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 1-4-49

Where did injury occur? Rockville (City or town) Monty (County) md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury: Struck by auto Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg md Date signed: 1-4-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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RECEIVED
JAN 10 1949
BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.0 0702

CERTIFICATE OF DEATH

93d Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Silver Spring, Md. LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mrs. Tolliffe's Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 252 - 9th St N E

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Stecklein

4. DATE OF DEATH (Month) Jan. (Day) 9 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH Apr. 17, 1870
9. AGE last birthday 78 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Washington DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank J. Stecklein
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Albert A Stecklein

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 6 hrs

Antecedent cause(s) (b) Arteriosclerotic Heart Dis. — Several Years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Renal Calculi

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-27, 1948, to 1-9, 1949, that I last saw the deceased alive on 1-3, 1949, and that death occurred at 2125 A m., from the causes and on the date stated above.

SIGNATURE John S. Rogers, M.D. (Degree or title) ADDRESS 9601 Sutton Pl. Silver Spring, Md. DATE SIGNED 1-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Jan. 12, 1949 NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery LOCATION (City, town, or county) (State) Wash DC.

DATE REC'D BY LOCAL REG. Jan 9, 1949 REGISTRAR'S SIGNATURE Josephine M. Schaeffer

24. FUNERAL DIRECTOR W. K. Huntemann ADDRESS 5732 Ga Ave Wash DC.

pa 5700

RECEIVED
JAN 12 1949
BUREAU V. S.

0703

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

754.5

CERTIFICATE OF DEATH

157 m

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring Md
LENGTH OF STAY (in this place) 55 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9009 Fairview Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 9009 Fairview Road

3. NAME OF DECEASED (Type or Print) (First) Anders (Middle) Clifford (Last) Stein

4. DATE OF DEATH (Month) January (Day) 16 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Oct 11 1893

9. AGE last birthday 55 yrs. If under 1 year: Months 3, Days 5; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Admin Officer USN Dept

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pigeon Cove Mass

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Emil Anders

14. MOTHER'S MAIDEN NAME Matilda Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW#1 USN 7/2/18 to 7/31/19

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Anders C. Stein (Wife) 9009 Fairview Rd., Silver Spring Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ruptured Coarctation of Aorta — Interval Between Onset and Death: 2 days

Antecedent cause(s) Coarctation

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death (1) Hypertension, (2) Parkinson's Disease — (1) ? (2) 10 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1938, to 16 Jan, 1949, that I last saw the deceased alive on 15 Jan, 1949, and that death occurred at 7:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) William D Aud, M.D. ADDRESS 9006 Colesville Rd Silver Spring, Md DATE SIGNED 16 Jan '49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Jan. 18, 1949 NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. LOCATION (City, town, or county) Fort Myer, Va. (State)

DATE REC'D BY LOCAL REG. Jan. 17, 1949 REGISTRAR'S SIGNATURE Josephine M. Schaeffer

24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., ADDRESS Silver Spring, Md.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0704

331
83a

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montg.

City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10000 Sa. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harrison W. Straley

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife: Rosa W. Straley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 30, 1863

8. AGE: Years: 85 Months: 8 Days: 18 If less than one day ..... hrs. ..... min.

9. Birthplace: Princeton, W. Va.
(Town, county, and state)

10. Usual occupation: attorney

11. Industry or business

FATHER
12. Name: Harrison W. Straley
13. Birthplace: Va

MOTHER
14. Maiden name: Delilah Byrnside
15. Birthplace: W. Va.

16. Informant: Garnet Straley

Address: 3261 Arcadia N.W.

17. ~~Burial~~ removal Date thereof Jan 18 1949
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

Location: Princeton, W. Va.

18. Funeral director: W.W. Deal

Address: 4812 Sa. Ave. N.W. Wash

19. Jan 18 1949 Josephine Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1949, at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30 1948, to Jan. 18 1949 and that I last saw him alive on Jan. 18 1949

Immediate cause of death: Acute myocarditis — DURATION: 2 wks.

Due to: Senility

Due to: Cerebral hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry M. Lowdere M.D.
M. D. or other

Address 1603 19th St. N.W. Date signed 1-18-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 20 1949
BUREAU V. S.

1948 8 17 48
~~X-X-18~~
85-4-30
1863-8-18

0705

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural)
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D. C. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 518 9th St., N.E.

3. NAME OF DECEASED (Type or Print): (First) STREEKS, (Middle) Benjamin (Last) Harrison

4. DATE OF DEATH: (Month) January (Day) 22 (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 11-8-69

9. AGE last birthday: 79 yrs. — If under 1 year: Months 2 Days 14 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: STREEKS, John F.

14. MOTHER'S MAIDEN NAME: PIERCE, Martha K.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Charlotte Streeks

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive Heart Disease — Interval Between Onset and Death: 1 yr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-19- , 1949, to 1-22-49, 1949, that I last saw the deceased alive on 1-22- , 1949, and that death occurred at 3:45 A m., from the causes and on the date stated above.

SIGNATURE W. F. Queen (Degree or title) ADDRESS DATE SIGNED
Wm. F. QUEEN, Cdr. MC USN U. S. Naval Hospital, Bethesda, Md. 1-22-49

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE THEREOF: 1-28-49 | NAME OF CEMETERY OR CREMATORY: Arlington National | LOCATION (City, town, or county): Arlington, | (State): Va.

DATE REC'D BY LOCAL REG.: 1-22-49 | REGISTRAR'S SIGNATURE: Mary G. Patterson | 24. FUNERAL DIRECTOR: Lee Funeral Home 4th & Mass. N.E. Wash. D.C. | ADDRESS

Mary G. Patterson

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0706

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING - PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 1 mon. 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington, D. C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): 525 7th St., S.E.

3. NAME OF DECEASED (Type or Print): (First) Andrew Dennis (Middle) (Last) Taylor

4. DATE OF DEATH: (Month) January (Day) 16, (Year) 1949

5. SEX: male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 2-20-73

9. AGE last birthday: 75 yrs. If under 1 year: Months 10 Days 28 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lawyer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: TAYLOR, Joseph

14. MOTHER'S MAIDEN NAME: TAYLOR, Susie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If year, give war or dates of service): Sp.Am.

16. SOCIAL SECURITY NO.:

17. INFORMANT: wife: Mrs. Fannie E. Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerosis generalized

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardiac Insufficiency

(c) Bronchial pneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-7, 1948, to 1-16-, 1949, that I last saw the deceased alive on 1-16, 1949, and that death occurred at 12:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James F. Berry
James F. BERRY, Lt JG MC USN, US. Naval Hospital, Bethesda, Md. 1-16-49

23. BURIAL, CREMATION REMOVAL (Specify): burial — DATE: 1-19-49 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG.: 1-16-49

REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR: Wm. J. Malley. E.J.N. ADDRESS: Malley, W.J., 522 8th St. S.E. Wash, D.C.

VS. A15

RECEIVED
JAN 18 1949
BUREAU V. D.

EVIDENCE FOR ADDITION IN # 18 C IS ON: FILM No. G 119

0707

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

MAR -7 1949

CERTIFICATE OF DEATH

223 56d

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda (rural)
LENGTH OF STAY (in this place): 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Washington, D. C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): 3221 Connecticut Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Lee (Last) Taylor

4. DATE OF DEATH: (Month) January (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: W-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 11-18-05

9. AGE last birthday: 43 yrs. If under 1 year: Months 2 Days 4 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Clerk

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: TAYLOR, Robert Lee.

14. MOTHER'S MAIDEN NAME: BLACKBURN, Fanny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY No.:

17. INFORMANT: wife: Mrs. Robert L. Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pneumonia

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c) Brain Tumor — Acoustic Neurinoma (left) Lipoma (Corpus Callosum)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1-11-49

19b. MAJOR FINDINGS OF OPERATION: Brain Tumor

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 27, 1949, to 1-22, 1949, that I last saw the deceased alive on 1-22, 1949, and that death occurred at 12 p m., from the causes and on the date stated above.

SIGNATURE: John C. McNerney (Degree or title) ADDRESS: Naval Hospital, Bethesda Md. DATE SIGNED: 1-22-49

J. C. McNerney US Naval Hospital Bethesda Md

23. BURIAL, CREMATION, REMOVAL (Specify): burial

DATE THEREOF: 1-26-49

NAME OF CEMETERY OR CREMATORY: Arlington National

LOCATION (City, town, or county) (State): Arlington, Va.

DATE REC'D BY LOCAL REG.: 1-22-49

REGISTRAR'S SIGNATURE: Mary C. Patterson

24. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS, 1400 Chapin St., N.W. Washington, D.C.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

323 562 0708

Reg. Dist. No. 215

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 7days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 months, 7days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1000 Mansion Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: THOMAS, Richard Branson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Amelia G. Thomas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 6, 1898

8. AGE: Years	Months	Days	If less than one day
50	0	28	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Civil Engineer

11. Industry or business: Retired from US Government

FATHER — 12. Name: THOMAS, John J. dec.

13. Birthplace: Md.

MOTHER — 14. Maiden name: THOMAS, Ada Elizabeth

15. Birthplace: Md.

16. Informant: wife: Mrs. Amelia G. Thomas

Address: 1000 Mansion Dr., Silver Spring, Md.

17. burial — Date thereof: 1-7-49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES

Address: 2901 14thSt., N.W., Wash., D.C.

19. 1-4- 19 49 (Date rec'd by registrar) Mary C. Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 January 19 49, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 19 48, to January 4 19 49

and that I last saw him alive on 4 January 19 49

Immediate cause of death	DURATION
(Brain Tumor)	
Due to: Meningioma	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. C. McNERNEY, Cdr. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-4-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0710

172
H825

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Jolliffe's Rest Home

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wash. County: D C

City or town: Washington D C
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME

SHIRLEY M. THOMPSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Franklin F. Thompson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 1896

8. AGE:	Years	Months	Days	If less than one day
	53			hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: William C. Fields
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary Gunther
15. Birthplace: Va.

16. Informant: Mrs. C. M. Robinson

Address: Statesville, N.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1949 (month) (day) (year)

Cemetery or crematory: Nat. Memorial Park

Location: Falls Church Va.

18. Funeral director: Chevy Chase Funeral Home

Address: 5101 Wisconsin ave. Wash. DC

19. Jan. 10 1949 (Date rec'd by registrar) Joseph W. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10 1949, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-24 1948, to 1-10 1949 and that I last saw h[illegible] alive on 1-9 1949

Immediate cause of death: Coronary Thrombosis

Due to: Locally

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: Not known But before I first saw her she complained of pain in left side

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John S. Rogers M.D.
M. D. or other

Address: 5101 Wisconsin Ave. Date signed: 1-10-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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1949
53
1896

RECEIVED
JAN 14 1949
BUREAU U.S.

0711

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

154
46d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
LENGTH OF STAY (in this place) 23 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs
STREET ADDRESS (If rural give location) 1000 Dennis Ave.

3. NAME OF DECEASED (Type or Print) (First) Lillian (Middle) V (Last) Tolson
4. DATE OF DEATH (Month) 1 (Day) 25 (Year) 1949
5. SEX F
6. COLOR OR RACE W
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) Single
8. DATE OF BIRTH Nov. 29, 1876
9. AGE last birthday 72 yrs. If under 1 year Months 1 Days 27 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Forestville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Edwin Tolson
14. MOTHER'S MAIDEN NAME Alice Rebecca Suit
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Circulatory collapse with severe cachexia	2 days
Antecedent cause(s)	(b) Metastatic carcinoma, abdominal viscera & cervical glands	1 year
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Carcinoma of rectum	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1946, to Jan 25, 1949, that I last saw the deceased alive on Jan 25, 1949, and that death occurred at 1:45 A.m., from the causes and on the date stated above.

SIGNATURE Thomas G.N. Hendman (Degree or title) M.D. ADDRESS 6 W. Washington St., Kensington, Md. DATE SIGNED 1/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-28-49
NAME OF CEMETERY OR CREMATORY Epiphany Epis. Ch. Cem.
LOCATION (City, town, or county) Forestville (State) Md.
DATE REC'D BY LOCAL REG. 1-25-49
REGISTRAR'S SIGNATURE W. E. Jobes
24. FUNERAL DIRECTOR J. Wm. Tuesons Co. ADDRESS Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

I

T

RECEIVED
JAN 28 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

610 0709

CERTIFICATE OF DEATH 468

Reg. Dist. No. 217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney; LENGTH OF STAY (in this place) 79 days.

HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; STREET ADDRESS (If rural, give location) R.F.D. #4 Manor Club.

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) (Last) Tompkins

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.

8. DATE OF BIRTH: Jan. 19, 1856

9. AGE last birthday: 93 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Plumbing Heating business

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Norfolk, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Washington Tompkins

14. MOTHER'S MAIDEN NAME: Sara Kennard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Infiltrating Carcinoma of Stomach — Interval Between Onset and Death: about 1 yr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____

(c) Chronic Prostatic Hypertrophy — 2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-14-48

19b. MAJOR FINDINGS OF OPERATION: Prostatectomy

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1/, 1948, to Jan. 31, 1949, that I last saw the deceased alive on Jan. 31, 1949, and that death occurred at 3:45 A m., from the causes and on the date stated above.

SIGNATURE J. M. Bird (Degree or title) M.D. ADDRESS Sandy Spring, Md. DATE SIGNED 1/31/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Feb. 2 1949 | NAME OF CEMETERY OR CREMATORY: Rock Creek | LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG.: Jan 31 - 1949 | REGISTRAR'S SIGNATURE: Gertrude B Lawler | 24. FUNERAL DIRECTOR: The S. H. Hines Co. | ADDRESS: 2901-14th St. N.W. Washington DC

RECEIVED
FEB 16 1949
BUREAU V. S.

0712

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

411/92 C

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred: 220 Elm Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Elm St. (If rural, give LOCATION)

2.(a) If veteran, name war Wars 1 & 2

3. (a) FULL NAME BRICE TOOLE

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Eleanor Toole

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.): January 19th 1895

8. AGE: Years 53 | Months 11 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace: Anaconda, Montana (Town, county, and state)

10. Usual occupation: Lawyer - Dept. of Justice

11. Industry or business

FATHER: 12. Name: John R. Toole

13. Birthplace: ?

MOTHER: 14. Maiden name: Anna Hardenbrook

15. Birthplace: ?

16. Informant: Mrs. Eleanor Toole

Address: 220 Elm St., Chevy Chase, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1/5/49 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Washington, D.C.

18. Funeral director: Wm Reuben Pumphrey Funeral Home.

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 1/6 1949 (Date rec'd by registrar) W. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4, 1949, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to January 1949 and that I last saw him alive on January 3, 1949

Immediate cause of death: Acute Myocardial Failure — DURATION: 15 mins.

Due to: Rheumatic Heart Disease with Aortic Stenosis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: James W. Long M.D. M. D. or other

Address: 1835 Eye St NW Date signed 1/4/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

RECEIVED
JAN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

981/166 Reg. Dist. No. 213

0713

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Boyds,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boyds
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Harold (Middle) Eugene (Last) Turner

4. DATE OF DEATH (Month) Jan (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 7, 1926
9. AGE last birthday 22 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Laborer
11. BIRTHPLACE (State or foreign country) Boyds, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Oscar Turner
14. MOTHER'S MAIDEN NAME Lummie Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes - (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 722-054770
17. INFORMANT Lummie Turner (Mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemorrhage due to

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) gun shot wound in rt. chest

(c)

INTERVAL BETWEEN ONSET AND DEATH: Killed instantly

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) homicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (CITY OR TOWN) Boyds (COUNTY) Monty (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) 1-8-49 8:15 P m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? gun shot (12 ga.)

22. I hereby certify that I attended the deceased from Sep. Med. 1949 to ..... case, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Frank J. Broschart M.D. (Degree or title) Sep. Med. Exam
ADDRESS Gaithersburg Md
DATE SIGNED 1-8-49

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE Jan. 12, 1949
NAME OF CEMETERY OR CREMATORY St. Marks
LOCATION (City, town, or county) Boyds, (State) Md

DATE REC'D BY LOCAL REG. 1-12-49
REGISTRAR'S SIGNATURE E P Thompson
24. FUNERAL DIRECTOR Robert L. Snowden, ADDRESS Rockville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

420.1 0714
93d

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Wash. San. & Hospital Takoma Pk. md.

How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Lee Street.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Ethel G. VanHoesen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	Widow

6.(b) Name of husband or wife: Deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1869.

8. AGE:

Years	Months	Days	If less than one day
79	7	15	hrs. min.

9. Birthplace: Cattaraugus Co N.Y.
(Town, county, and state)

10. Usual occupation: Retired teacher.

11. Industry or business:

FATHER
12. Name: David Grove
13. Birthplace: Cattaraugus Co N.Y.

MOTHER
14. Maiden name: Caroline Thompson
15. Birthplace: Cattaraugus Co N.Y.

16. Informant: Record.

Address: Wash. San. & Hosp. Takoma Pk. md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan. 6, 1949 (month) (day) (year)

Cemetery or crematory:

Location: Franklinville, Cattaraugus Co. New York

18. Funeral director: Warner E. Pumphrey, Inc.

Address: Silver Spring, Md.

19. Jan 5 1949 (Date rec'd by registrar) J. Hilton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1949 at 9 05 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1945 to Jan. 3 1949 and that I last saw h-- alive on January 3 1949

Immediate cause of death	DURATION
Complete heart block	1 wk.
Due to: Coronary infarct	1 wk.
Due to: Hypertensive cardio-vascular disease	about 5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Katharine A. Chapman, M.D.
M. D. or other

Address: 2012 West Baltimore St. Date signed 1/3/49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 7 1949
BUREAU V. S.

0715

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

154
46d

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Ch. Ch. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Ch Ch. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Oxford St.
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Charles Thompson Vance

3. (b) Social Security Number None

4. Sex M.

5. Color or race W.

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elizabeth Hamilton

6.(c) If alive, give age 79? years

7. Birth date of deceased (mo., day, yr.) May 27 - 1867

8. AGE: Years 81. Months Days If less than one day ... hrs. ... min.

9. Birthplace Vincennes Ind.
(Town, county, and state)

10. Usual occupation Ret.

11. Industry or business

FATHER
12. Name Joseph Vance
13. Birthplace Pa.

MOTHER
14. Maiden name Mary Maddox
15. Birthplace Ind.

16. Informant J. Hamilton Vance
Address 111 Lucas Lane Ch Ch Md

17. Burial Date thereof 1-24-49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek

Location Wash. D.C.

18. Funeral director Jas. Gawlers Sons
Address 1756 Pa Ave N.W.

19. 1-22 1949 W. E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1949, at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 1947, to JANUARY 1949 and that I last saw him alive on JANUARY 21, 1949

Immediate cause of death CARCINOMA OF RECTUM

Due to —

Due to —

Other conditions TERMINAL UREMIA

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ADENOCARCINOMA OF RECTUM. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold Sterling, Md. M. D. or other

Address 3100 Connecticut Ave N.W. Date signed Jan 27, 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

292.4
73a

0716

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred: 45 Poplar ave Takoma Park
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5416- 30th Pl N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: Livingston Vann Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ or wife: Josie Spencer Vann
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 11 1860

8. AGE: Years	Months	Days	If less than one day
88	1	0	hrs. min.

9. Birthplace: Madison Florida (town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: E. J. Vann
13. Birthplace: Thomasville Georgia

MOTHER
14. Maiden name: Margaret Livingston
15. Birthplace: Bennettville S. C.

16. Informant: Mrs Miriam E. Roth
Address: 45 Poplar ave. Takoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan- 14-1949 (month) (day) (year)
Cemetery or crematory: Geo. Washington Mem.
Location: Riggs Rd. Pr Geo. Co.

18. Funeral director: The S. H. Hines Co.
Address: 2901- 14th St. N.W.

19. Jan- 11 1949 (Date rec'd by registrar) J. Ethan Doll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1949 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1941 to Jan- 11 1949 and that I last saw h~~im~~ alive on Jan. 11 1949

Immediate cause of death	DURATION
APLASTIC ANEMIA -	9 MOS.
Due to	
Due to	
Other conditions ①. PERNICIOUS ANEMIA -	7 YRS
②. ARTERIOSCLEROSIS GEN.	20 YRS

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Leeppos M.D.
M. D. or other
Address: 4100- 14th St N.W. WASH DC Date signed 1/11/49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 13 1949
BUREAU V. S.

0717

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

151
460

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) — LENGTH OF STAY (in this place) 1 mon. 26days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital	STREET ADDRESS (If rural, give location) 1352 Irvin St., N.W.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William		WALSH	January	27	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US	married	11-16-92	56 yrs.	2	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tax Examiner	US Government	Mass.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WALSH, Edward	LEE, Mary H.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWI		wife: Mrs. Angela M.Walsh

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subdural Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Stomach

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
23 Jan 1949	Right Subdural Hematoma	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 29 Nov., 1948, to 27 Jan., 1949, that I last saw the deceased alive on 27 Jan., 1949, and that death occurred at 2:57 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John C. McNerney, Cdr. MC USN	US Naval Hospital, Bethesda, Md.	1-27-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-29-49	Arlington National	Arlington, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-27-49	Mary G. Patterson	S. H. HINES, 2901 14th St., N.W., Wash., D.C.	

VS. A15

RECEIVED
FEB 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0718

7720

158

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Bridge St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME STANLEY LEWIS WARD Jr.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife ---

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 2, 1948

8. AGE: Years	Months	Days	If less than one day
	8	29	... hrs. ... min.

9. Birthplace Bethesda, Maryland
(Town, county, and state)

10. Usual occupation ---

11. Industry or business ---

FATHER 12. Name Stanley L. Ward Sr.
13. Birthplace Gaithersburg, Md.

MOTHER 14. Maiden name Lillian Johnson
15. Birthplace Bethesda, Md.

16. Informant Stanley L. Ward Sr.
Address 23 Bridge St. Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1949 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg, Md.

18 Funeral director Wm. Reuben Brumbley Funeral Home
Address Bethesda, Maryland

19. 1-4 1949 E P Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1949 at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31st 1948 to Jan 1 1949
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Malnutrition	some time.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Jno. J. Bouchat M.D. M. D. or other
Address Gaithersburg Md. Date signed 1-2-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 6 1949
BUREAU V. S.

Evidence for change of birth date and age is on: Film No.G119, Feb.18,1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0719

002 13 15

Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 1326 S. St. S.E.

3. NAME OF DECEASED (Type or Print) (First) Agnes (Middle) Matilda (Last) Weible

4. DATE OF DEATH (Month) 1 - (Day) 21 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Oct 17 1896
9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Altoona, Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Detemple
14. MOTHER'S MAIDEN NAME Anna Oswald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Tuberculosis, Pulmonary, far advanced with extensive cavitation — INTERVAL BETWEEN ONSET AND DEATH: not known

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) J.L.H.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Tuberculosis of kidneys J.L.H. — not known

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 18, 1949, to Jan 21, 1949, that I last saw the deceased alive on Jan 20, 1949, and that death occurred at 9:17 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert A Hare M.D. ADDRESS Takoma Park, Md. DATE SIGNED 1-21-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 1/25/49 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. Jan 21-1949 REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR T.F. Costello ADDRESS 1722-N. Capitol St. Wash, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU U. S.

0720

447

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (rural) | LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 1339 Newton St., N. W.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Theodore	Francis	WERNER	January 18 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	W-US		12-15-86	62 yrs.	1	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Library Congress	California	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WERNER, Alois	BUTLER, Barbara

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes	WWI		sister: Miss Tillie Werner, 515 E. 20th St., Oakland, Calif.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Nephritis, Chronic. — Undetermined

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension, Arterial — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Tuberculosis, Pulmonary, Reinf. Mod. Adv.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan. 4, 1949, to Jan. 18, 1949, that I last saw the deceased alive on Jan 18, 1949, and that death occurred at 6 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. F. Queen
Wm. F. QUEEN, Cdr. MC USN, U. S. NAVAL HOSPITAL, Bethesda, Md. 1-19-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	1-24-49	Arlington National	Arlington, Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-18-49	Mary C. Patterson	W. W. CHAMBERS,	1400 Chapin St., N.W. Wash., D.C.

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VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0721

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2

CERTIFICATE OF DEATH

93d Reg. Dist. No. 223

1. PLACE OF DEATH · COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (In this place) 4½ days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colonial Heights, Petersburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San + Hosp	STREET ADDRESS (If rural, give location) 605 Hamilton Ave.

3. NAME OF DECEASED (Type or Print) (First) Henry (Middle) Clark (Last) WILCOX

4. DATE OF DEATH (Month) Jany (Day) 29 (Year) 1949

5. SEX M

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH July 8, 1863

9. AGE last birthday 85 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Colporteur

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Berlin, Conn.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME John V. Wilcox

14. MOTHER'S MAIDEN NAME Mary — ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Pts. chart.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH 5 days

Antecedent cause(s) (b) Myocarditis — several years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany 24, 1949, to Jany 29, 1949, that I last saw the deceased alive on Jany 29, 1949, and that death occurred at 1:34 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John N. Andrews M.D. ADDRESS Silver Spring Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Feb. 1, 1949 — NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery — LOCATION (City, town, or county) Bladensburg Rd at District Line, (State) D.C.

DATE REC'D BY LOCAL REG. 1/29/49 — REGISTRAR'S SIGNATURE J. Wilson Dodd — 24. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St. New York PK. D.C. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 31 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0722

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Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edmor (rural)
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY: Howard (Monty)
STATE: Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellicott City
STREET ADDRESS (If rural give location): rural

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Kenneth (Last) Yeatman

4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 19X9

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 8-19-1911

9. AGE last birthday: 37 yrs. — If under 1 year: Months 4, Days 27, If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: law

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Rudolph H. Yeatman

14. MOTHER'S MAIDEN NAME: Mary V. Cantwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service) W. War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm H. Yeatman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Compound fracture of skull

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: killed instantly

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: highway

(CITY OR TOWN): Mt. Edmor (COUNTY): Monty (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): 1-16-49 10 P m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? auto accident

22. I hereby certify that I attended the deceased from Dec 16 med. Exam Case 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 10:00 P....m., from the causes and on the date stated above.

SIGNATURE: Frank J. Brosnahan (Degree or title) M.D. — ADDRESS: Gaithersburg Md. — DATE SIGNED: Dec 16 med. Exam.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Jan. 19, 1949 — NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — LOCATION (City, town, or county) (State): Suitland, Md.

DATE REC'D BY LOCAL REG.: Jan. 19, 1949 — REGISTRAR'S SIGNATURE: Josephine E. Schaeffer

24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. — ADDRESS: Silver Spring Md.

RECEIVED
JAN 20 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 414

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edmor (rural) | LENGTH OF STAY (in this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
STREET ADDRESS (If rural give location) rural

3. NAME OF DECEASED (Type or Print): (First) La Dosca (Middle) Hodges (Last) Yeatman
4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 19X9
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Mar. 16, 1913
9. AGE last birthday: 35 yrs. | If under 1 year: Months 10 Days 0 | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): supervisor
10b. KIND OF BUSINESS OR INDUSTRY: Probation office D.C.
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Julius C. Hodges
14. MOTHER'S MAIDEN NAME: Pearl L. Forsythe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Wm H. Yeatman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fracture of cervical Vertebrae — killed instantly

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: highway
(CITY OR TOWN): m. Edmor (COUNTY): Monty (STATE): md
TIME OF INJURY (Month) (Day) (Year) (Hour): 1-16-49 10 P.m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? auto accident

22. I hereby certify that I attended the deceased from Dec. 16 Med. Exam. case 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 10:00 P.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) Frank J. Bronhart M.D. ADDRESS Gaithersburg DATE SIGNED Dec. 16 Med. Exam. Maryland

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Jan. 19, 1949 | NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery | LOCATION (City, town, or county): Suitland, Md. (State)

DATE REC'D BY LOCAL REG.: Jan. 19, 1949 | REGISTRAR'S SIGNATURE: Josephine M. Schaeffe

24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. ADDRESS: Silver Spring, Md.

RECEIVED
JAN 20 1949
BUREAU V. S.